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No. _____

In The

Supreme Court of the United States

October Term, 1990

THE LOUISIANA PATIENT'S COMPENSATION FUND,

Petitioner,

versus

WALLY EUGENE STUKA AND LORNA MARIE STUKA,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF THE STATE OF LOUISIANA

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QUESTIONS PRESENTED

1. The Louisiana Patient's Compensation Fund ("the Fund") is a special fund of the Louisiana State Treasury comprised of private monies held by the State in trust for the use, benefit and protection of medical malpractice claimants and the Fund's voluntary health care provider contributors. Is the Fund protected by the Fourteenth Amendment guarantee against deprivation of property without due process of law?

2. Under the Louisiana law the Fund is liable to a maximum of $500,000 to any single medical malpractice claimant for any amount in excess of the total liability of all liable health care providers, each of whose liability, if they are members of the Fund, is limited to $100,000. Is the Fund entitled, as required by the guarantee of due process, to a trial on the issue of liability in a case involving several potentially liable health care providers where the claimant settled with one of the health care providers, released and dismissed the others, and sought to recover damages in excess of the settlement amount from the Fund?

LIST OF PARTIES

The parties to the proceeding below were:

Wally Eugene Stuka

Lorna Marie Larrieu Stuka

Dr. Michael O. Fleming

Dr. Marion Cash

Dr. Ricky L. Jones

Michael O. Fleming and Ricky L. Jones (A Medical Corporation)

St. Paul Fire and Marine Insurance Company

The Louisiana Patient's Compensation Fund

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THE LOUISIANA PATIENT'S COMPENSATION FUND,

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WALLY EUGENE STUKA AND LORNA MARIE STUKA,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF THE STATE OF LOUISIANA

The petitioner, the Louisiana Patient's Compensation Fund (hereinafter referred to as "the Patient's Compensation Fund" or "the Fund"), prays that a writ of certiorari issue to review the Judgment and Opinion of the Supreme Court of the State of Louisiana entered in the above entitled proceeding on May 17, 1990, with regard to which rehearing was denied on June 28, 1990.

OPINIONS BELOW

The opinion of the Supreme Court of the State of Louisiana is not yet reported, but is reprinted in the Appendix hereto, App. 1, *infra*.

The Louisiana Supreme Court's denial of petitioner's application for rehearing is unreported but reprinted in the Appendix hereto, App. 25, *infra*.

The opinion of the First Judicial District Court, State of Louisiana, was rendered orally and not transcribed. The judgment incorporating this opinion is reprinted in the Appendix hereto, App. 73, *infra*.

The Louisiana Second Circuit Court of Appeal's granting of writs of certiorari from the trial court judgment is unreported but reprinted in the Appendix hereto, App. 76, *infra*.

The opinion of the Louisiana Second Circuit Court of Appeal is reported at 532 So.2d 1204 and is reprinted in the Appendix hereto, App. 78, *infra*.

The Louisiana Supreme Court's granting of respondents' writ on the initial decision of the Louisiana Second Circuit Court of Appeal and remanding the case to said court for briefing, argument and opinion is reported at 536 So.2d 1206 and is reprinted in the Appendix hereto, App. 82, *infra*.

The opinion of the Louisiana Second Circuit Court of Appeal, on remand, is reported at 543 So.2d 1374 and is reprinted in the Appendix hereto, App. 83, *infra*.

The Louisiana Supreme Court's granting of respondents' writ of certiorari from the opinion of the Louisiana

Second Circuit Court of Appeal, on remand, is reported at 548 So.2d 313 and is reprinted in the Appendix hereto, App. 100, *infra*.

JURISDICTION

Petitioner seeks review of the judgment of the Louisiana Supreme Court entered in these proceedings on May 17, 1990. Rehearing of that decision was timely sought and was denied on June 28, 1990. The jurisdiction of this Court to review this matter is invoked under 28 U.S.C. Section 1257.

STATUTES INVOLVED

The following statutory provisions involved have been printed in the Appendix:

> Louisiana Revised Statutes 40:1299.41 through 40:1299.48.

STATEMENT OF THE CASE

On February 20, 1987, plaintiffs-respondents, Wally Eugene Stuka and Lorna Marie Stuka (hereinafter referred to as "respondents") filed suit in Louisiana State District Court against three physicians alleging that Mrs. Stuka had received negligent medical treatment at their

hands. In their suit, respondents asked for a trial by jury on their claims. At some point between the filing of suit and August of 1988, respondents, through their attorney, entered into settlement discussion with St. Paul Fire and Marine Insurance Company (hereinafter referred to as "St. Paul"), the professional liability carrier for all three of the physicians, as well as for the professional medical corporation which employed them. An agreement was reached in which St. Paul agreed to pay respondents, on behalf of its four insureds (the three physicians and the professional medical corporation), the sum of $100,000 in exchange for full and complete releases. This settlement was reflected in a first supplemental and amending petition filed by respondents on August 10, 1988 (App. 26, *infra*), which, *inter alia*, named petitioner, the Louisiana Patient's Compensation Fund ("the Fund"), as an additional defendant. The petition requested court approval of St. Paul's settlement, with reservation by respondents of their rights against the Fund for additional damages as provided by the Louisiana Patient's Compensation Fund Law.

The Fund is a special fund of the State Treasury for the benefit of medical malpractice claimants and the Fund's private health care provider members. It was created by Act 817 of the 1975 Louisiana Legislature (La. R.S. 40:1299.41, *et seq*)[1], which limits the total recovery for any

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[1] In response to a perceived medical malpractice crisis during the 1970s, several states passed similar legislation. Schrero, *Patient Compensation Funds: Legislative Response to the Medical Malpractice Crisis*, 5 Am. J. Law & Medicine 175 (1979).

(Continued on following page)

injury or death of a malpractice claimant, exclusive of future medical expenses, to $500,000. The statute also provides that a qualified health care provider shall not be liable for more than $100,000 for injury or death of any one patient. Any amount due from a judgment, settlement or arbitration award in excess of the total liability of all liable health care providers is paid from the Fund.

Participation in the Fund is voluntary. A health care provider may elect to qualify by filing, with the State Commissioner of Insurance, proof of malpractice insurance in the amount of $100,000, or proof of financial responsibility in excess of $100,000, and by paying an annual insurance premium surcharge as determined by the Louisiana Insurance Rating Commission. The surcharges are paid into the Fund. The Act provides that the Fund is not public money but is private and held in trust as a custodial fund by the State for the use, benefit and protection of malpractice claimants and the health care provider members.[2]

(Continued from previous page)

The Louisiana statute is most similar to that of Indiana, after which the Louisiana statute was modeled. Indiana Code Ann. Sec. 16-19.5-1-1 to 16-19.5-9-10. However, no other state, either by legislation or judicial decision, provides for recovery to the claimant of damages without regard for the liability of other potentially liable health care providers. For example see the Colorado, Kansas, Nebraska and Pennsylvania statutes. Colorado Rev. Stats. 10-4-801, *et seq*; Kansas Stats. Ann. 40-3410, *et seq*; Rev. Stats. Nebraska, Reissue of 1984, 44-2801, *et seq*; Purdon's Pennsylvania Stats. Ann., Title 40, Sec. 1301.101, *et seq*.

[2] The statute was amended in 1988, during the pendency of this matter. Specifically, the last sentence of Section

(Continued on following page)

As noted above, a qualifying health care provider is not liable in excess of $100,000 for death or injury of a patient. The Fund, then, is liable to the patient for any excess over the total liability of all liable health care providers up to the maximum recovery of $500,000.

If a health care provider (or its insurer) agrees to settle its liability and the claimant is demanding an excess of $100,000, an adversarial proceeding is commenced against the Fund in a district court of competent jurisdiction. This proceeding is initiated by claimants' obtaining court approval of the settlement with the health care provider by way of a hearing. The hearing procedure is set forth in La. R.S. 40:1299.44C(5), which states:

> "At the hearing the commissioner, the claimant and the insurer of the health care provider or the self-insured health care provider as the case may be, may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if it is submitted on agreement without objections. If the commissioner, the insurer of the health care provider or the self-insured heath care provider as the case may be, and the claimant cannot agree on the amount, if any, to be paid out of the patient's compensation fund, then the court shall determine the amount of claimant's damages, if any, in excess of the amount already paid by the

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1299.44A(1) was amended to provide that the state recognized the private nature of the Fund. (App. 115, *infra*) Prior to amendment, the last sentence of that section read: "The Fund and any income from it shall be held in trust, and all such funds and income shall be subject to use and dispersion only as provided in this section." The change appears to have been made for purposes of clarification and did not affect substantive rights.

> insurer of the health care provider. The court shall determine the amount for which the fund is liable and render a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid from the patient's compensation fund, the court shall consider the liability of the health care provider as admitted and established where the insurer has paid its policy limits of one hundred thousand dollars, or where the self-insured health care provider has paid one hundred thousand dollars."

The last sentence is the crux of this controversy. It was misconstrued by the Supreme Court of Louisiana as meaning that the Fund's liability was established whenever one of several potentially liable health care providers settled for $100,000 without regard to the liability of those providers that did not settle.

In the case at bar, respondents filed the appropriate motion to fix a hearing to obtain court approval of their settlement with St. Paul (*supra*). This request for hearing was contained in a lengthy pleading entitled "First Supplemental and Amending Petition of Plaintiffs-Claimants for Permission to Obtain Approval of Settlement with Qualified Health Care Providers, Reserving Any and All Rights They Have Against Said Health Care Providers in Their Capacity as Qualified Health Care Providers Under the Louisiana Malpractice Act, the State of Louisiana, Hon. Douglas Green, Commissioner of Insurance and the Louisiana Patient's Compensation Fund; and for Declaratory Judgment for the Court to Determine the Amount of the Claimants' Damages and the Amount to be Paid From the Patient's Compensation Fund, All Pursuant to La. R.S. 40:1299.44(C)" (App. 26, *infra*). The settlement was

approved by the trial judge on September 14, 1988 (See App. 59, *infra*). The following day, the Fund filed its answer (See App. 61, *infra*), raising certain affirmative defenses and requesting a jury trial. In response to this answer, respondents filed a motion to strike certain of the Fund's affirmative defenses (App. 65, *infra*). All pending motions were argued on October 11, 1988. Following oral argument, the trial judge granted respondents' motion to strike paragraphs 4, 5 and 6 of the Fund's answer, which contested the issues of liability in this case. It also, *sua sponte*, ordered the Fund's request for a jury trial, contained in paragraph 9 of the answer, stricken, although this relief had not been originally prayed for by respondents (See App. 73, *infra*). The Fund timely applied for writs to the Louisiana Second Circuit Court of Appeal from this ruling. In a published opinion, *supra*, the Louisiana Second Circuit Court of Appeal vacated the trial court judgment granting respondents' motion to strike and remanded the case to the trial court for further proceedings in accordance with law. In this opinion, the Court of Appeal both recognized the Fund's right to a trial by jury and held that since the settlement of this case was with multiple health care providers for a single $100,000 amount, the provisions of La. R.S. 40:1299.44C(5), quoted above, dealing with the admission of liability, did not come into play, as respondents did not obtain the maximum amount, $100,000, from each health care provider (532 So.2d at 1205). The Louisiana Second Circuit Court of Appeal therefore classified the settlement as a "partial settlement" (*supra*) that did not trigger the admission of liability language of the statute.

Respondents timely applied to the Louisiana Supreme Court for writs from this decision. On January 13, 1989, the Louisiana Supreme Court remanded the case to the Court of Appeal for further proceedings (See App. 82, *infra*). The Louisiana Second Circuit Court of Appeal subsequently rendered a second opinion, (543 So.2d 1374, See App. 83, *infra*) which basically reaffirmed its prior holding. Once again, respondents applied for writs to the Louisiana Supreme Court, which were again granted (See App. 100, *infra*). Judgment was rendered in the Louisiana Supreme Court on May 17, 1990, following oral argument. This judgment, while upholding the Fund's right to trial by jury, held that the Fund was precluded from contesting issues of liability because of the payment by St. Paul of $100,000 to the respondents. The appellate court had found that the $100,000 settlement was paid the respondents on behalf of three health care providers without apportionment and, therefore, under the statute their fault and liability was not deemed admitted under the statute (534 So.2d at 1379). The Supreme Court, however, simply found that the statute did not expressly provide for the case in which multiple health care providers were joined as a defendant and only one settled for the amount of $100,000. It concluded that once payment by any one of the several potentially liable health care providers triggered the statutory admission of liability, the Fund could not contest that admission. The only issue between the victim and the Fund thereafter was the amount of damages sustained by the victim of the admitted malpractice. The Supreme Court in its opinion expressly recognized that its literal interpretation

afforded the Fund less rights when claims against multiple health care providers are settled than when such claims are tried because, in case of a trial, the Fund could reduce its exposure when more than one provider was found liable. In cases of settlement, however, according to the Court, the legislature "chose . . . simply to declare the admission of liability by the $100,000 payment of one health care provider and did not provide for the Fund's affirmative right to litigate liability on the part of any other named or unnamed health care providers" (___ So.2d at ___, App. 9, *infra*). The Louisiana Supreme Court overturned the decision of the appellate court, but it did not limit its decision to the facts of this case, *i.e.*, multiple health care providers insured by one insurance company. Instead, it made a much broader ruling, interpreting the language of the statute to hold that any time any health care provider or its insurer paid the sum of $100,000, the Fund was precluded from contesting issues of liability as to any remaining defendants, even those who had contributed nothing toward such a settlement. Petitioner timely filed an application for rehearing of the decision of the Louisiana Supreme Court (See App. 12, *infra*). As was permitted under the rules of the Louisiana Supreme Court, this application was filed in a bifurcated manner. The federal constitutional issues were enunciated in the initial application (App. 12, *infra*) and given substance, with appropriate citations to constitutional authorities, in the supplement thereto which was timely filed (App. 15, *infra*). In denying rehearing, the Louisiana Supreme Court did not discuss the constitutional questions raised by applicant. (The Louisiana Supreme Court's granting of certiorari, as is customary with that court, did not specify

the issues on which it wished to consider argument. As petitioner had been uniformly successful in maintaining its position in the lower appellate court, there was no reasonable basis for it believing that the Louisiana Supreme Court would rule as it did until it rendered its May 17 opinion.)

REASONS FOR GRANTING THE WRIT

I.

The Supreme Court of the State of Louisiana has Rendered a Decision as to an Important Issue of Constitutional Law as to which the Federal Appellate Courts are in Conflict and which Should be Settled by this Court.

On its application for rehearing and in its supporting brief, the petitioner raised for the first time, which was also its first opportunity, the argument that the decision of the Supreme Court of the State of Louisiana was in violation of the Constitution of the United States as amounting to a deprivation of property without due process. The Louisiana Supreme Court denied the petitioner's application for rehearing without comment. In so doing, the Louisiana Supreme Court implied either that due process of law does not require that the Fund be granted a hearing on the issue of liability, or that the Fund is not entitled to claim the guarantee of due process in any case. If the Fund is a private or quasi-private entity, it is of course entitled to due process protection. As the money in the Fund is not public money but private funds held in custody by the State for the use, benefit and protection of malpractice claimants and the Fund's members (La. R.S. 40:1299.44A(1), App. 114, *infra*), the only

real connection that the State of Louisiana has with the Fund is that the Attorney General and the Commissioner of Insurance act as trustees for the benefit of the private health care providers.[3] The Fund should therefore be entitled to all due process guarantees available to other natural and juridical persons. Obviously the private health care providers who pay into the Fund have a property interest in its administration. The amount that they pay each year depends on the balance in the Fund (La. R.S. 40:1299.44A(6), App. 119, *infra*) which, of course, depends not only on the collections but on the claims paid. In *every instance* in which Louisiana courts have been asked to adjudicate issues where the status of the Fund as a state entity *vel non* would bring different results, the courts have uniformly applied rules as they pertain to the private sector. For example, the Fund, and claimants against the Fund, have uniformly been granted the right to trial by jury, which is not available with regard to claims by and against the State (*Stuka v. Fleming*, La., ___ So.2d ___ (1990); *Williams v. Kushner*, La., 449 So.2d 455 (1984)). Additionally, Louisiana courts have applied the private legal interest rate, as opposed to the public interest rate, in computing recovery against the Fund (*LaMark v. NME Hospitals, Inc.*, 522 So.2d 634 (La. App. 4th Cir. 1988), *cert denied*, La., 526 So.2d 803 (1988)).

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[3] The 1990 Louisiana Legislature enacted changes in the manner in which the Fund is administered, basically replacing the Attorney General's function with that of an appointed board. As the effective date of this legislation is October 1, 1990, its enactment obviously has no bearing on this case.

It would be inconsistent with these decisions for this Court now to classify the Fund as a state agency in order to deprive it of due process protection. However, assuming *arguendo*, that the Fund should be considered analogous to a state agency, this position raises an unresolved constitutional issue as to which the federal appellate courts are in conflict. The issue is whether, and under what circumstances, a state agency or political subdivision, might claim the guarantee of due process of the Fourteenth Amendment against actions of the state that created it.

Several appellate opinions have stated that political subdivisions of a state may not challenge the validity of a state statute under the Fourteenth Amendment. (*South Macomb Disposal Authority v. Township of Washington*, 790 F.2d 500 (6th Cir. 1986); *Town of Ball v. Rapides Parish Police Jury*, 746 F.2d 1049 (5th Cir. 1984); *Village of Arlington Heights v. Regional Transportation Authority*, 653 F.2d 1149 (7th Cir. 1981); *City of South Lake Tahoe v. California Tahoe Regional Planning Agency*, 625 F.2d 231 (9th Cir. 1980), *cert denied*, 449 U.S. 1039, 101 S.Ct. 619 (1980); *City of Safety Harbor v. Birchfield*, 529 F.2d 1251 (5th Cir. 1976); *City of New York v. Richardson*, 473 F.2d 923 (2nd Cir. 1973)).

However, the Fifth Circuit and, more recently, the Eleventh Circuit, have rejected the notion that a municipality or state agency has standing to challenge the constitutionality of state actions. In *Rogers v. Brockette*, 588 F.2d 1057 (5th Cir. 1979), *cert denied*, 444 U.S. 827, 100 S.Ct. 52 (1979), the Fifth Circuit rejected the contention that a state independent school district lacked standing to challenge the constitutionality of a state statute that it

claimed was in conflict with a federally subsidized breakfast program. The *Rogers* case was followed by the Eleventh Circuit in *United States v. State of Alabama*, 791 F.2d 1450 (11th Cir. 1986). The court concluded that the *Rogers* case was binding on the Eleventh Circuit and that there was no *per se* rule prohibiting creations of the state from invoking constitutional objections to state actions.

The apparent conflict in the circuits over the standing of municipalities to assert constitutional objections was noted by Justice White in a dissent from the denial of certiorari in *City of South Lake Tahoe v. California Regional Planning Agency, supra.* There Justice White said:

> "The Court of Appeals also held that the city had no standing because a political subdivision of a State may not raise constitutional objections to the validity of a state statute, . . . Such a per se rule is inconsistent with (*Board of Education v. Allen*, 392 U.S. 236, 88 S.Ct. 1923 (1968)), in which one of the appellants was a local board of education. Furthermore, there is a conflict in the Circuits over the validity of such a rule." (Citations omitted) (449 U.S. at 1041-42).

The dissent from the denial of certiorari was noted in the Ninth Circuit opinion in *San Diego Unified Port District v. Gianturco*, 651 F.2d 1306 (9th Cir. 1981). There, the court concluded that, because a party other than the Port District that clearly had standing to sue had intervened, it need not resolve the issue of whether the Port District had standing to assert constitutional objections against the State, or another entity of the State. Nevertheless, the court observed:

> "While there are broad dicta that a political subdivision may never sue its maker on constitutional grounds, . . . we doubt that the rule is so broad." (651 F.2d at 1309).

Indeed, the rule certainly is not, or should not be, as broad as suggested by the *City of South Lake Tahoe v. California Regional Planning Agency, supra* and *City of New York v. Richardson, supra,* and other opinions. The *South Lake Tahoe* opinion quotes the *New York* opinion:

> "It is well established that '(p)olitical subdivision of a state may not challenge the validity of a state statute under the Fourteenth Amendment.' " (625 F.2d at 233 quoting 473 F.2d at 929).

Both, however, rely on a series of Supreme Court cases that themselves seem to acknowledge that municipalities, or state political subdivisions, are not *per se* barred from asserting constitutional objections to state actions. See, *Coleman v. Miller,* 307 U.S. 433, 59 S.Ct. 972 (1939); *Williams v. Mayor and City Council of Baltimore,* 289 U.S. 36, 53 S.Ct. 431 (1932); *City of Trenton v. State of New Jersey,* 262 U.S. 182, 43 S.Ct. 534 (1923); *Pawhuska v. Pawhuska Oil & Gas Co.,* 250 U.S. 394, 39 S.Ct. 526 (1918); *Hunter v. City of Pittsburgh,* 207 U.S. 161, 28 S.Ct. 40 (1907); *Monterey v. Jacks,* 203 U.S. 360 (1906); *Worcester v. Worcester Consolidated Street Ry. Co.,* 196 U.S. 539 (1904); *City of Covington v. Commonwealth of Kentucky,* 173 U.S. 231 (1899); *City of New Orleans v. New Orleans Water Works Co.,* 142 U.S. 79, 12 S.Ct. 142 (1891); *Essex Public Road Board v. Skinkle,* 140 U.S. 334, 11 S.Ct. 790 (1891); *Board of Commissioners v. Lucas,* 93 U.S. 108 (1876); *Commissioners of Laramie County v. Albany County,* 92 U.S. 307 (1875). Of this line of cases, Justice

Frankfurther in *Gomillion v. Lightfoot*, 364 U.S. 339, 81 S.Ct. 125 (1960) said:

> "They are authority only for the principle that no constitutionally protected contractual obligation arises between a state and its subordinate governmental entities solely as a result of their relationship." (364 U.S. at 343).

Indeed, most of the opinions observe, or indicate, that where the municipality holds property in its proprietary capacity, it is entitled to the same protection from arbitrary state actions as an individual or private corporation. (*Coleman v. Miller, supra; Hunter v. Pittsburgh, supra; Monterey v. Jacks, supra; Worcester v. Worcester Consolidated Street Ry. Co., supra; City of New Orleans v. New Orleans Water Works Co., supra; Essex Public Road Board v. Skinkle, supra; Board of Commissioners v. Lucas, supra; South Macomb Disposal Authority v. Township of Washington, supra.* Also see, *N.O., Mobile and Texas Railroad Company v. Ellerman*, 105 U.S. 166 (1881)).

In the *Coleman* case the Court said:

> "Being but creatures of the State, municipal corporations have no standing to invoke the contract clause of the provisions of the Fourteenth Amendment of the Constitution in opposition to the will of their creator. But there has been recognition of the legitimate interest of public officials and administrative commissions, federal and state, to resist the endeavor to prevent the enforcement of statutes in relation to which they have official duties." (307 U.S. at 441, 442).

In *Monterey v. Jacks*, the Court said that lands acquired by municipalities through purchase or special grant are beyond the power of the state to dispose of

without consent of the municipality in question. (203 U.S. at 362-63).

In the *Worcester* case, the Court acknowledged that, in general, a municipal corporation could own private property, and that such property may be entitled to constitutional protection, in which case the property could not be diverted by the legislature. (196 U.S. at 551).

The *New Orleans Water Works* case said that a municipality was a mere agent of the state with no contract relation with its sovereign. The state is free to amend, change or revoke the charter of the city at its pleasure without impairment of constitutional obligations. However, with respect to its private or proprietary rights the city may be entitled to constitutional protection. (142 U.S. at 91).

The *Essex Public Road* case found that the Board, established by the state, could not complain of a denial of due process when its property was diverted by the state in accordance with a state statute because the Board was purely a government agency existing wholly for public purposes, and whose interests belonged exclusively to the public. It, therefore, could not hold real estate in a proprietary or private sense and was not entitled to claim protection from state action. (140 U.S. at 339, 342).

In *Board of Commissioners v. Lucas*, the Court in speaking of municipal corporations said:

> "Their tenure of property, derived from the State for specific public purposes, or obtained for such purposes through means which the State alone can authorize, – that is, taxation, – is so far subject to the control of the legislature, that the property may be applied to other public

> uses of the municipality than those originally designated. This follows from the nature of such bodies, and the dependent character of their existence. But property, derived by them from other sources is often held, by the terms of the grant, for special uses, from which it cannot be diverted by the legislature. In such cases, the property is protected by all the guards against legislative interference possessed by individuals and private corporations for their property." (93 U.S. at 114-115).

The case presented here is one in which the state has acknowledged the private, non-public, nature of the Fund. The Fund should, therefore, be entitled to all constitutional protection afforded private parties. Alternatively, this case is one in which the Court should settle the issue of the so called rule that a political subdivision might never challenge the constitutionality of state actions.

II.

The Supreme Court of Louisiana has rendered a Decision that Denies the Petitioner the Most Basic Requirement of Due Process.

The basic requirement of due process is the opportunity to be heard "at a meaningful time and in a meaningful manner." (*Mathews v. Eldridge*, 424 U.S. 319, 96 S.Ct. 893 (1976); *Wolff v. McDonnell*, 418 U.S. 539, 94 S.Ct. 2963 (1974); *Board of Regents v. Roth*, 408 U.S. 564 (1972); *Armstrong v. Manzo*, 380 U.S. 545, 552, 85 S.Ct. 1187, 1191 (1965)). In *Mathews v. Eldridge, supra*, the Court set forth a three-part litmus test to determine the presence *vel non* of a due process violation, namely, (1) the nature of the private interest being affected; (2) the risk of erroneous

deprivation of such interest through the procedures used and the availability and value of other procedures; and (3) the interest of the government in following the procedures used, including fiscal and administrative burdens and like (96 S.Ct. at 902). Here the Supreme Court of Louisiana has denied the Fund the opportunity for hearing on the issue of liability while, ironically, granting the Fund its prayer for a jury trial, albeit on the issue of quantum only, on the grounds that "fundamental fairness requires that the Fund, forced into litigation to respond for excess damages, should also be afforded the right to request a trial by jury in defending against such claims" (___ So.2d ___ at ___, App. 9, *infra*). The statute in question seems much clearer that the Fund is entitled to test the liability of all potentially liable health care providers, than that the Fund is entitled to a jury trial. Indeed, the statute is silent as to whether the Fund is entitled to a jury trial on the matter of quantum, but it clearly states, in Section 40:1299.42B(3), that the Fund's liability is in excess of the total of all liable health care providers. The Supreme Court of Louisiana, however, relied entirely on another section of the statute, Section 40:1299.44C(5), that requires the court to "consider the liability of the health care provider as admitted and established where the insurer has paid its policy limits of one hundred thousand dollars . . . " Although that section seems to leave open the question of the liability of other potentially liable health care providers, the Supreme Court of Louisiana flatly said:

> " . . . Once payment by one health care provider has triggered the statutory admission of liability, the Fund cannot contest that admission. The only issue between the victim and the Fund

> thereafter is the amount of damages sustained by the victim as a result of the admitted malpractice.
>
> "We recognize that this literal interpretation of the statute affords less rights to the Fund when claims against multiple health care providers are settled than when such claims are tried. In the case of a trial the fund has the opportunity for reduced exposure when more than one health care provider is determined to be liable. But in the case of settlement with one health care provider for $100,000 the Fund does not have this opportunity in the subsequent litigation with the victim. However, the Legislature chose in cases of settlement simply to declare the admission of liability by the $100,000 payment of one health care provider and did not provide for the Fund's affirmative right to litigate liability on the part of any other named or unnamed health care providers." (La., ___ So.2d ___, ___ (1990)).

If that were the Legislature's intent, it chose incredibly subtle language to convey it. The point, however, is not merely that the Supreme Court of Louisiana was mistaken in its interpretation of a Louisiana statute, although that point seems clear. The opinion of the Supreme Court of Louisiana is impossible to reconcile with the language and purpose of the statute. As the opinion itself recognized, the statute is silent on whether the Fund is entitled to a trial on liability in the situation of this case. Other language in the statute indicates that the legislature intended the Fund to have such a right and certainly public policy favors a right to try the liability of the defendants who have not settled. Ironically, the Supreme Court of Louisiana found that the Fund was

entitled to a jury trial as to damages because, "fundamental fairness requires that the Fund, forced into litigation to respond to excess damages, should also be afforded the right to request a trial by jury in defending against such claims" (___ So.2d at ___, App. 9, *infra*). Fundamental fairness is the touchstone of due process. It is certainly difficult to square the notion that fundamental fairness requires a jury trial on the issues of damages with a predetermination of liability based on language that is, according to the Court's own opinion, ambiguous. The unfairness in this case is self evident from the fact that the other health care providers, expressly made defendants, who might be liable to the plaintiff to the maximum extent of $100,000, are in effect released and the Fund required to bear the entire balance of damages to the maximum of $500,000. Under the Court's ruling, a plaintiff has no incentive to try liability as to a nonsettling defendant. This can have the potential and disturbing effect of allowing a health care provider, guilty of malpractice, to walk away from financial responsibility, thus raising the "risk of erroneous deprivation," the second prong of *Mathews v. Eldridge, supra* due process test. If a medical review panel finds two separate health care providers equally culpable, this decision means that the one which accepts responsibility first will insulate the other from liability. This of course conveys no additional benefit to the malpractice victim, who would then merely look to the Fund to make up the monetary difference. However, the nonsettling defendant would reap a totally undeserved windfall that the Fund itself would then pay, to the overall detriment of its private members. It is submitted that there is no legitimate government interest

in allowing such a procedure to exist, the third prong of the *Mathews* test. Moreover, in its extreme, it creates a situation which is ripe for abuse, in that it would encourage malpractice defendants to secretly pool their resources to create a single $100,000 settlement in the name of one of them.

The point is that the error as to the Fund's right to a trial on liability is so far from what could reasonably be expected as to amount to a deprivation of the Fund's property without due process. The point is illustrated by the case of *Brinkerhoff-Faris Trust & Savings Company v. Hill*, 281 U.S. 673 (1930). The *Brinkerhoff* case is closely similar to this one. The Savings Company, as trustee, sued to enjoin collection of certain state taxes as a denial of equal protection, alleging that its stock, held by its shareholders, was assessed for tax purposes at full value whereas other classes of property were assessed at 75% of value for the same purposes. The Supreme Court of Missouri dismissed the plaintiff's petition on the grounds that its remedy was to apply to the State Tax Commission, which by then it was out of time to do. In reaching that conclusion the Supreme Court of Missouri reversed an earlier opinion in which it had said that the Tax Commission was without jurisdiction to grant the sort of relief sought by the plaintiff. The Supreme Court said that the case concerned the question of due process in its primary sense, the opportunity to present its case and to be heard. It said:

> "Undoubtedly, the state court had the power to construe the statute dealing with the State Tax Commission; and to reexamine and overrule the *Laclede* case. Neither of the matters raises a federal question; neither is subject to our review.

> But, while it is for the state courts to determine the adjective as well as the substantive law of the State, they must, in so doing, accord the parties due process of law. Whether acting through its judiciary or through its legislature, a State may not deprive a person of all existing remedies for the enforcement of a right, which the State has no power to destroy unless there is, or was, afforded to him some real property to protect it." (281 U.S. at 681-682).

III.

The Petitioner Timely Raised Its Constitutional Complaint.

The constitutional issues in this case were originally raised by petitioner in its application for rehearing to the Louisiana Supreme Court. Prior to the May 17, 1990, decision of the Louisiana Supreme Court, no federal question had been apparent in this case. Before that opinion was rendered, petitioner's right to a trial on the issue of liability had twice been affirmed by the lower appellate court on statutory grounds (App. 78, 83, *infra*). The district court had not given written reasons for striking petitioner's prayer for trial on liability and its oral statement for reasons had not been transcribed. It therefore does not appear that the issue was "pressed or passed upon" in the lower courts, and its being raised at the stage that it was should be considered timely (*Illinois v. Gates*, 462 U.S. 213, 103 S.Ct. 2317 (1983); *Brinkerhoff-Faris Trust & Savings Company v. Hill, supra*).

CONCLUSION

This petition for Writ of Certiorari should be granted to correct the denial of due process to the petitioner and, if necessary, to settle the conflict among the federal courts of appeal as to whether, and under what circumstances, state agencies or subdivisions may invoke the guarantee of due process of the Fourteenth Amendment.

Respectfully submitted,

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MAY 17 1990

SUPREME COURT OF LOUISIANA

NO. 89-CC-1391

WALLY EUGENE STUKA, ET UX

versus

DR. MICHAEL FLEMING, ET AL

Writ of Certiorari to the Court of Appeal,
Second Circuit, Parish of Caddo

JUSTICE LEMMON*

The issue in this case is whether the Patient's Compensation Fund (the Fund), created by La. Rev. Stat. Ann. 40:1299.44, may contest its liability to a medical malpractice victim who has compromised his claim against one health care provider for $100,000, while voluntarily dismissing others, and is seeking recovery against the Fund of damages in excess of the settlement amount. We conclude that payment of $100,000 to a medical malpractice victim by one qualified health care provider (or the provider's insurer) triggers the admission of the liability provision of La. Rev. Stat. Ann. 40:1299.44C(5), and the only contested issue remaining thereafter between the victim and the Fund is the amount of the victim's damages in excess of the amount already paid.

Plaintiffs filed this action against Dr. Michael Fleming, Dr. Ricky Jones and Dr. Marion Cash, alleging that plaintiff wife had been treated by the three associated doctors between November, 1985 and March, 1986 for

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*Retired Chief Justice John A. Dixon, Jr. participated in this case, having been a member and Chief Justice of this court when the case was orally argued and taken under advisement.

sinus problems, that she developed severe nausea, vomiting and headaches, and that she was ultimately diagnosed as having a brain abscess caused by sinus infection.[1] The petition alleged that substandard medical care by the three doctors caused her to undergo surgery and to suffer residual brain damage and susceptibility to seizures.

Plaintiffs and the doctors' malpractice insurer thereafter reached an agreement to settle the claim. Plaintiffs filed an amended petition seeking judicial approval of the settlement agreement pursuant to La. Rev. Stat. Ann. 40:1299.44C.[2] In the amended petition plaintiffs added as defendants the medical corporation which employed the three doctors, the medical malpractice insurer of the doctors and the corporations, the State of Louisiana, and the Fund. Under the terms of the settlement the insurer agreed to pay $100,000 on behalf of Dr. Jones and the corporation.[3] In return plaintiffs agreed to release Dr. Jones, the medical corporation and the insurer, reserving their rights against Dr. Jones, the medical corporation, the insurer and the fund to the extent necessary to preserve their claim for damages in excess of $100,000 from the

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[1] The record consists only of the pleadings. No evidence was presented at the hearing which led to the judgment now at issue.

[2] References hereafter to Sections 1299 mean that Section of Title 40.

[3] The amended petition essentially restated the allegations of the original petition, but focused on the allegedly substandard care rendered by Dr. Jones and did not assert any negligence by the other doctors.

Fund. Plaintiffs further agreed to dismiss with prejudice any claims against Dr. Fleming and Dr. Cash.

After the twenty-day period provided by Section 1299.44C(3) elapsed without any opposition to the settlement, the trial court rendered judgment approving the settlement. The judgment noted that the trial as to the amount of damages, if any, due by the Fund was to be conducted at a later date.

The Fund then filed an answer, denying negligence on the part of any health care provider and asserting its right to litigate the issue of liability. The Fund contended that the $100,000 settlement which resulted in the dismissal of four health care providers did not constitute an admission of liability under Section 1299.44C(5).[4] The Fund also requested a jury trial on all issues.

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[4] Section 1299.44C(5), pertaining to the procedure when a health care provider has agreed with the victim to settle its liability and the victim is demanding an amount in excess of the settlement from the Fund, provides:

> At the hearing the commissioner [the administrator of the Fund], the claimant and the insurer of the health care provider or the self-insured health care provider as the case may be, may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if it is submitted on agreement without objections. If the commissioner, the insurer of the health care provider or the self-insured health care provider as the case may be, and the claimant cannot agree on the amount, if any, to be paid out of the patient's compensation fund, then the court shall determine the amount of claimant's damages, if any, in excess of

(Continued on following page)

Plaintiff then filed a motion to strike the jury trial request and to strike the Fund's opposition to the court's considering the settlement as an admission of liability.

The trial court rendered judgment on the motion, striking the jury trial and effectively ruling that the settlement constituted an admission of liability as between plaintiffs and the Fund. The court of appeal reversed, declaring the Fund's right to litigate the issue of liability and granting the Fund's request for a jury trial.[5] 543 So.2d 1374. The intermediate court recognized that plaintiffs had settled, according to the terms of the agreement, only with Dr. Jones, the medical corporation and their insurer, and had received no additional consideration for the voluntary release of Dr. Fleming and Dr. Cash. However, the court characterized the settlement as one of a potential $400,000 claim against four health care providers (three doctors and the medical corporation) for

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(Continued from previous page)

> the amount already paid by the insurer of the health care provider. The court shall determine the amount for which the fund is liable and render a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid from the patient's compensation fund, *the court shall consider the liability of the health care provider as admitted and established where the insurer has paid its policy limits of one hundred thousand dollars, or where the self-insured health care provider has paid one hundred thousand dollars.* (emphasis added).

[5] The court of appeal initially granted certiorari and issued a peremptory writ reversing the judgment. 532 So.2d 1204. On plaintiffs' application this court remanded the case to the court of appeal for a full opinion. 536 So.2d 1306.

$100,000.[6] Because the insurer had not paid $100,000 on behalf of *each* named health care provider, the court held that the issue of liability may be litigated by the Fund.

This court granted certiorari. 548 So.2d 313.

The Medical Malpractice Act, enacted by La. Acts 1975, No. 817, provides a scheme for compensation of medical malpractice victims who have been injured by qualified health care providers. Section 1299.42B(2) limits the liability of a *single* qualifiled [sic] health care provider to $100,000 for the injury to or death of any one person. Under Section 1299.42B(3) damages in excess of the total liability of *all* liable health care providers, up to $500,000, are to be paid by the Fund. Thus, according to the Act, if a suit is tried against two health care providers and a definitive judgment is rendered holding each legally responsible for the victim's damages which are found to exceed $200,000, the liability of each health care provider is $100,000, and the potential liability of the Fund is $300,000, with a total recoverable amount of $500,000.[7]

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[6] Although there were four health care providers named in the supplemental petition, the only negligence alleged was by the three doctors. The corporation therefore could only be vicariously liable, and the potential claim against the three doctors under the Act was limited to $300,000.

[7] The constitutionality of the $500,000 limitation was challenged in *Williams v. Kushner*, 549 So.2d 294 (La. 1989). This court held that the limitation of the Fund's liability to $400,000 was not unconstitutional, inasmuch as that body had no liability whatsoever beyond the statute which created it. However, because the plaintiff had compromised his claim against the sole health care provider for $100,000 prior to trial, there was no remaining defendant which could be liable for the

(Continued on following page)

See *Kelty v. Brumfield*, 534 So.2d 1331 (La. App. 4th Cir. 1988), *cert. denied*, 536 So.2d 1221 (1989).

The present case does not involve the trial of a suit against multiple health care providers, but involves the settlement of a claim against *one* health care provider in a suit against several. Section 1299.44C provides the procedure when "*a* health care provider . . . has agreed to settle *its* liability" and the victim desires to pursue his claim against the Fund for an amount in excess of the settlement. (emphasis supplied). The victim files a petition seeking approval of the settlement and demanding additional damages from the Fund. Section 1299.44C(1). The Commissioner of Insurance, as administrator of the Fund, must be served with a copy of the petition, Section 1299.44C(2), and may agree or object to the amount demanded within twenty days. Section 1299.44C(3). If the parties cannot agree on the amount to be paid by the Fund, the court must conduct a trial to determine the amount of the victim's damages in excess of the amount already paid by the health care provider or his insurer. In approving the settlement or determining the amount to be paid by the Fund, the court considers the liability of the health care provider as admitted if the health care provider or the insurer on his behalf has paid $100,000. Section 1299.44C(5).

Thus, under the express terms of Sections 1299.44C, the malpractice victim's settlement with one health care

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damages in excess of $500,000. Therefore, this court did not reach the issue of the constitutionality of either the $100,000 or the $500,000 limitations on recovery.

provider or his insurer for $100,000 not only triggers the Fund's liability for excess damages, if any, but also precludes the Fund from contesting *that* health care provider's liability. The issue in this case is whether the result is different when other health care providers have been joined in the suit and are dismissed along with the release of the health care provider who paid $100,000.

The statute does not make any express provisions for a case in which multiple health care providers have been joined as defendants and only one pays $100,000 in settlement. We interpret the overall statute as dispensing with the litigation of liability between the victim and the Fund after one health care provider has paid $100,000 in settlement.

A suit under the Medical Malpractice Act is against the health care provider only and not against the Fund. The health care provider is the only party defendant contemplated by the Act. *Williams v. Kushner,* 449 So.2d 455 (La. 1984). Indeed, the statute does not require joining the Fund as a defendant, but only requires serving the administrator of the Fund with the petition for approval of the settlement when *a* health care provider has agreed to settle *its* liability to the malpractice victim.

The status of the Fund, after a settlement between the malpractice victim and a health care provider for $100,000, is more in the nature of a statutory intervenor than a party defendant. As an intervenor the Fund may put on evidence and unite with the defendant in resisting the victim's demands, and may appeal a judgment, but may not object to the form of the action. *Williams v. Kushner,* 449 So.2d at 458. Moreover, when a judgment in

excess of $100,000 has been rendered in a suit between the malpractice victim and the health care provider, the Fund may appeal the excess judgment against the Fund. *Felix v. St. Paul Fire and Marine Insurance Co.*, 477 So.2d 676 (La. 1985).

The Medical Malpractice Act therefore contemplates that the issue of liability is generally to be determined between the malpractice victim and the health care provider, either by settlement or by trial, and that the Fund is primarily concerned with the issue of the amount of damages.[8] Payment by one health care provider of the maximum amount of his liability statutorily establishes that the plaintiff is a victim of that health care provider's malpractice. Once payment by one health care provider has triggered the statutory admission of liability, the Fund cannot contest that admission. The only issue between the victim and the Fund thereafter is the amount of damages sustained by the victim as a result of the admitted malpractice.

We recognize that this literal interpretation of the statute affords less rights to the Fund when claims against multiple health care providers are settled than when such claims are tried. In the case of a trial the Fund has the opportunity for reduced exposure when more than one health care provider is determined to be liable. But in the case of a settlement with one health care

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[8] The Fund may be concerned with the issue of liability when, for example, the only named health care provider settles with the malpractice victim for less than $100,000.

provider for $100,000 the Fund does not have this opportunity in the subsequent litigation with the victim. However, the Legislature chose in cases of settlement simply to declare the admission of liability by the $100,000 payment of one health care provider and did not provide for the Fund's affirmative right to litigate liability on the part of any other named or unnamed health care providers.

We accordingly conclude that, because of the payment of $100,000 by Dr. Jones' insurer in this case, the only issue to be litigated between plaintiffs and the Fund is the quantum of damages.

As to the jury trial issue, we agree with the reasoning of the court of appeal that since *Williams v. Kushner*, 449 So.2d 455 (La. 1984), affords the tort victim the right to a jury trial in post-settlement litigation with the Fund over the amount of damages to be paid by the Fund, then "fundamental fairness requires that the Fund, forced into the litigation to respond for excess damages, should also be afforded the right to request a trial by jury in defending against such claims". 543 So.2d at 1378. This reasoning is especially applicable here inasmuch as Dr. Jones and the corporation, who are still in the litigation to a limited extent and are now represented by the Fund's attorney, have withdrawn their waiver of a jury trial.

For these reasons the judgment of the court of appeal is reversed insofar as it recognized the Fund's right to litigate the issue of liability. The case is remanded to the district court for further proceedings.

MAY 17 1990

SUPREME COURT OF LOUISIANA

No. 89-CC-1391

WALLY EUGENE STUKA, ET UX

Versus

DR. MICHAEL FLEMING, ET AL

DENNIS, J., concurring in part, dissenting in part.

I respectfully concur in the major holding that "payment of $100,000 to a medical malpractice victim by one qualified health care provider (or the provider's insurer) triggers the admission of the liability provision of La. Rev. Stat. Ann. 40:1299.44C(5), and the only contested issue remaining thereafter between the victim and the Fund is the amount of the victim's damages in excess of the amount already paid."

I respectfully dissent from the additional holding that the Patients' Compensation Fund has a right to a jury trial. After a plaintiff compromises with a health care provider, his claim for additional recovery necessarily must be asserted against the Fund. The Fund may be viewed as money held in trust by the state, or one of its departments, or as a separate legal entity. See La. R.S. 40:1299.44(A). If the Fund is considered to have a separate legal existence, however, it should be viewed as an entity of the state. For the Fund has no home, head or governing body except that of a creature or entity of the state. Consequently, a plaintiff's suit against the Fund is either a suit against the state as trustee or against the Fund as an entity of the state and cannot be tried by a jury. La. R.S. 13:5101, 5102, 5105. This rationale is difficult to reconcile with *Felix v. St. Paul Fire & Marine Ins. Co.*,

477 So.2d 676 (La. 1985) and *Williams v. Kushner*, 449 So.2d 455 (La. 1984), but, in light of the true nature of the plaintiff's claim and the Fund's relationship with the state, our failure to modify the basis of our decisions in this context may lead to greater problems.

I respectfully express doubts and reservations as to other statements in the court's opinion. For example, it does not seem to follow that a release of a health care provider always causes the release of another health care provider bound with him vicariously and solidarily. See generally C.C. art. 1803; *Sampay v. Morton Salt Co.*, 395 So.2d 326 (La. 1981). Further, I am reluctant to conclude that the Fund may never be made to pay more than $400,000 for injuries contributed to by more than one health care provider-tortfeasor. Whether a single limitation applies to damages caused by plural defendants may depend on such factors as whether the defendants engaged in concerted action, whether the damages are severable, or whether the damages may be apportioned between the tortfeasors. Compare *Hilburn v. Johnson*, 240 So.2d 767 (La. App. 2d Cir. 1970) with *Hess v. Sports Publishing Co.*, 520 So.2d 472 (La. App. 4th Cir.), writ denied, 523 So.2d 1343 (1988); cf. W. Keeton, D. Dobbs, R. Keeton & D. Owen, Prosser and Keeton on Torts § 52 (5th ed. 1984).

WALLY EUGENE STUKA AND LORNA MARIE LARRIEU STUKA
VERSUS
DR. MICHAEL FLEMING, ET AL

No.: 89-CC-1391

SUPREME COURT OF LOUISIANA

APPLICATION FOR REHEARING

NOW INTO COURT, through undersigned counsel comes, THE LOUISIANA PATIENT'S COMPENSATION FUND, defendant-applicant herein, and with respect represents:

1.

Defendant-applicant requests a rehearing of the Court's ruling of May 17, 1990, insofar as said ruling deals with the effect on the remaining potential issues in the case of payment by a qualified health care provider on its insurer in the sum of $100,000.00.

2.

Defendant-applicant believes that this Court's prior ruling involves an interpretation of La.R.S. 40:1299.44C(5) which is unconstitutional under the Constitution of the State of Louisiana and/or the United States, in that it constitutes a taking without due process of assets of defendant-applicant by denying defendant-applicant the right to contest issues of liability under the facts of this case.

3.

Defendant-applicant shows that this Court's ruling has given rise to the above described federal question for

the first time, as that all prior appellate court rulings had been in favor of defendant-applicant.

4.

Defendant-applicant requests until June 30, 1990, within which to file its brief in support of this applications, which, *inter alia*, will amplify the above constitutional issues.

WHEREFORE, DEFENDANT-APPLICANT, THE LOUISIANA PATIENT'S COMPENSATION FUND PRAYS that its application for rehearing be filed.

FURTHER PRAYS that it be granted until June 30, 1990, to file its brief in support of this application.

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PATIENT'S COMPENSATION FUND

WALLY EUGENE STUKA AND LORNA MARIE LARRIEU STUKA

VERSUS

DR. MICHAEL FLEMING, ET AL

No.: 89-CC-1391

SUPREME COURT OF LOUISIANA

ORDER

UPON CONSIDERATION OF THE FOREGOING, let Louisiana Patient's Compensation Fund be given until June 22, 1990, to file its brief in support of its application for rehearing.

Done and signed in New Orleans, Louisiana, this ___ day of May, 1990.

/s/ _____
Justice

SUPREME COURT OF

LOUISIANA

NUMBER 89-CC-1391

WALLEY EUGENE STUKA AND LORNA MARIE STUKA — Plaintiffs-Applicants

VS.

DR. MICHAEL FLEMING, ET AL — Defendants-Respondents

Application for Rehearing to the Supreme Court, State of Louisiana

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ORIGINAL BRIEF IN SUPPORT OF APPLICATION FOR REHEARING OF DEFENDANTS-RESPONDENTS, THE LOUISIANA PATIENT'S COMPENSATION FUND, DR. RICKEY L. JONES AND DR. RICKEY L. JONES and DR. MICHAEL O. FLEMMING (A PROFESSIONAL MEDICAL CORPORATION)

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13. *Williams v. St. Paul Companies*, 419 So 2d 1302 (La. App. 4th Cir. 1980), *cert denied*, La., 423 So 2d 1182 (1980).....4

MAY IT PLEASE THE COURT:

This Honorable Court is by now well familiar with the facts of this case. They will not be repeated here. The issue was clearly stated in the first sentence of this Court's opinion, namely, " . . . whether The Louisiana Patient's Compensation Fund (the Fund), created by La. Rev. Stat. Ann. 40:1299.44 may contest its liability to a medical malpractice victim who has compromised his claim against one health care provider for $100,000.00, while voluntarily dismissing others, and is seeking recovery against the Fund of damages in excess of the settlement amount"? This Honorable Court then went on in fact to interpret the statute in a much broader context than was necessary to decide this narrow issue, and, in so

doing, has emasculated The Louisiana Patient's Compensation Fund insofar as multiple-defendant medical malpractice actions are concerned. By doing this, the Court has *not* provided any added benefits to victims of medical malpractice but, instead, has bestowed a windfall on nonsettling defendants (which are principally insurance companies) and has created a situation ripe for fraud and deceit. It has also placed an unconstitutional interpretation on the legislation in question by denying the Fund opportunity to limit its monetary losses in multiple-defendant cases.

Due process is guaranteed by the Fifth and Fourteenth Amendments to the Constitution of the United States and by Section 2, Article 1 of the Louisiana Constitution of 1974. While it is not susceptible to a precise definition, due process is generally equated with fundamental fairness, or the opportunity to be heard "at a meaningful time and in a meaningful manner." (*Armstrong v. Manzo*, 380 U.S. 545, 552, 85 S.Ct. 1187, 1191 (1965); *e.g., Lassiter v. Department of Soc. Serv.*, 452 U.S. 18, 101 S.Ct. 2153 (1981); *Little v. Streater*, 452 U.S. 1, 101 S.Ct. 2202 (1981); *Connecticut Bd. of Pardons v. Dumschat*, 452 U.S. 458, 101 S.Ct. 2460 (1981); *Matthews v. Eldridge*, 424 U.S. 319, 96 S.Ct. 893 (1976); *Board of Regents v. Roth*, 408 U.S. 564 (1972)). In *Matthews v. Eldridge, supra*, the United States Supreme Court set forth a three-part litmus test to determine the presence *vel non* of a due process violation, namely, (1) the nature of the private interest being affected; (2) the risk of erroneous depravation of such interest through the procedures used and the availability and value of other procedures; and (3) the interest of the government in following the procedures used, including

fiscal and administrative burdens and like (96 S.Ct. at 902). It is submitted that all three criteria require a much stricter interpretation of the admission of liability provision of the Louisiana Medical Malpractice Act than has been applied by the Court, both as to the actual issue with which this Court was presented in this case and the scope of the decision as rendered.

The Louisiana Patient's Compensation Fund was created by La. R.S. 40:1299.44A(1) as a special fund to be held in trust by the State of Louisiana, subject to use only as provided by the statute. The source of the funds is a surcharge on the cost of each health care provider's maintenance of financial responsibility. The amount of the surcharge is determined by the Louisiana Insurance Rating Commission based on actuarial principles not to exceed 20% of such costs, or, in the case of self-insureds, an amount determined by the Commissioner of Insurance based on what the health care provider's cost of financial responsibility would be. The functions of collecting and administering the Fund are delegated to the Commissioner of Insurance. The function of protecting the Fund is delegated to the Attorney General. [The 1988 amendments to the statute provide that the Fund is not public money but is private and held in trust as a custodial fund by the State for the use, benefit and protection of malpractice claimants and the health care provider members.[1]

---

[1] It is submitted that this amendment was merely a clarification of the Fund's status and not a substantive change in the law.

It is therefore submitted that the only real connection that the State of Louisiana has with The Louisiana Patient's Compensation Fund is that the Attorney General and the Commissioner of Insurance act as trustees for the benefit of the private health care providers. The Fund should therefore be entitled to all due process guarantees available to other natural and juridical persons. Obviously the private health care providers who pay into the Fund have a property interest in its administration. The amount that they pay each year depends on the balance in the Fund (La. R.S. 40:1299.44A(6)) which, of course, depends not only on the collections but on the claims paid. While certain statutory language describes the Fund as a "budgetary unit" of the State of Louisiana, it is interesting to note that in *every instance* in which Louisiana courts have been asked to adjudicate issues where the status of the Fund as a state entity *vel non* would bring different results, the courts have uniformly applied rules as they pertain to the private sector. For example, the Fund, and claimants against the Fund, have uniformly been granted the right to trial by jury, which is not available with regard to claims by and against the State (*Stuka v. Fleming*, La., ___ So 2d ___ (1990); *Williams v. Kushner*, La., 449 So 2d 455 (1984)). Additionally, Louisiana courts have applied the private legal interest rate, as opposed to the public interest rate, in computing recovery against the Fund (*LaMark v. NME Hospitals, Inc.*, 522 So 2d 634 (La. App. 4th Cir. 1988), *cert denied*, La., 526 So 2d 803 (1988)). It would be inconsistent with these decisions for this Court not to classify the Fund as a state agency in order to deprive it of due process protection. This Court's own opinion in this case has implicitly

acknowledged that the Fund is entitled to due process. On the point of whether the Fund was entitled to a jury trial, this Court agreed with the Court of Appeals that since the claimant was entitled to a jury trial in post-settlement litigation over damages, "fundamental fairness requires that the Fund, forced into litigation to respond to excess damages, should also be afforded the right to request a trial by jury in defending against such claims" (*Supra* at ___). Fundamental fairness is the touchstone of due process. It means, at a minimum, the opportunity to be heard at a meaningful time and in a meaningful manner (*Matthews v. Eldridge, supra, Armstrong v. Manzo, supra*). It is certainly difficult to square the notion that fundamental fairness requires a jury trial on the issues of damages with a predetermination of liability based on language that is, according to the Court's own opinion, ambiguous. The unfairness in this case arises from the fact that the other health care providers, expressly made defendants, who might be liable to the plaintiff to the maximum extent of $100,000.00, are in effect released and the Fund required to bear the entire balance of damages to the maximum of $500,000.00. Under the Court's ruling, a plaintiff has no incentive to try liability as to a nonsettling defendant. This can have the potential and disturbing effect of allowing a health care provider, guilty of malpractice, to walk away from financial responsibility, thus raising, the "risk of erroneous deprivation," the second prong of the *Matthews v. Eldridge* due process test. If a medical review panel finds two separate health care providers equally culpable, this Court's decision means that the one which accepts its responsibility first will insulate the other from liability.

This of course conveys no additional benefit to the malpractice victim, who would then merely look to the Fund to make up the monetary difference. However, the non-settling defendant would reap a totally undeserved windfall that the Fund itself would then pay, to the overall detriment of its private members. It is submitted that there is no legitimate government interest in allowing such a procedure to exist, the third prong of the *Matthews* test. Moreover, in its extreme, it creates a situation which is ripe for abuse, in that it would encourage malpractice defendants to secretly pool their resources to create a single $100,000.00 settlement in the name of one of them. This could be done with or without the knowledge of the plaintiff, who, being paid his or her $100,000.00, would have no reason to inquire as to its source, knowing that he or she could now look to the Fund for any additional sums up to the statutory limit.] Given the number of multiple-defendant medical malpractice actions, it is submitted that the Fund could not financially survive repeated applications of such an abusive practice.

CONCLUSION

The provisions of the Louisiana Medical Malpractice Act have traditionally been given strict construction by the courts of this state. (*Head v. Erath Gen. Hosp.*, 458 So 2d 579 (La. App. 3d Cir. 1984), *cert denied*, La. 462 So 2d 650 (1984); *Williams v. St. Paul Cos.*, 419 So 2d 1302 (La. App. 4th Cir. 1982), *cert denied*, La., 423 So 2d 1182 (1982)). This appears to be the first instance in which a Louisiana court has purposefully gone beyond a literal reading of the statute in order to reach a particular result. In so

doing, it is submitted that this Court has violated fundamental fairness requirements of due process to which The Louisiana Patient's Compensation Fund is clearly entitled. It has in effect deprived The Louisiana Patient's Compensation Fund and, by definition, its private members, of their full day in court with regard to health care providers from which a claimant has not extracted a single $100,000.00 settlement, both under the facts of this particular case and under the scope of this Court's ruling. In so doing, it has economically deprived the Fund members both of the right to hold accountable these non-paying entities and, even more importantly, of its right to contest issues of liability and therefore protect its fiscal integrity. When an act is susceptible of two constructions, one of which would make it unconstitutional, and the other of which would uphold its constitutionality, a court should adopt the latter (*Jackson v. Coxe*, 208 La. 715, 23 So 2d 312 (1945); *In re Interstate Trust & Banking Co.*, 204 La. 323, 15 So 2d 369 (1943)). With no justification and without statutory support, it is submitted that this Court, in its decision, has adopted an unconstitutional interpretation of the Louisiana Medical Malpractice Act and, in so doing, has violated the fundamental fairness requirements of due process for the benefit of no one but malpractice tortfeasors. This decision should therefore not be allowed to stand or, at the very least, be limited to the particular facts of this case.

Respectfully submitted,

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CERTIFICATE

I HEREBY CERTIFY that a copy of the above and foregoing brief has been this day forwarded to all counsel of record in the captioned matter by depositing a copy of the same, postage prepaid, in the United States Mail.

Shreveport, Louisiana, this 20th day of June, 1990.

/s/ Jerald L. Perlman
Jerald L. Perlman
Of Counsel

SUPREME COURT OF LOUISIANA

FOR IMMEDIATE NEWS RELEASE

NEWS RELEASE #074

FROM: CLERK OF SUPREME COURT OF LOUISIANA

On the *28th day of June, 1990,* the following action was taken by the Supreme Court of Louisiana in the cases listed below:

REHEARINGS DENIED:

89-CC- 1391 WALLY EUGENE STUKA AND LORNA MARIE LARRIEU STUKA v. DR. MICHAEL FLEMING, ET AL (Parish of Caddo)

* * *

WALLY EUGENE STUKA & LORNA MARIE LARRIEU STUKA	§	NUMBER: 330,930
VERSUS	§	FIRST JUDICIAL DISTRICT COURT
DR. MICHAEL FLEMING, ET AL	§	CADDO PARISH, LOUISIANA

ASSIGNED TO: JUDGE HAMILTON

FIRST SUPPLEMENTED AND AMENDING PETITION OF PLAINTIFFS-CLAIMANTS FOR PERMISSION TO OBTAIN APPROVAL OF SETTLEMENT WITH QUALIFIED HEALTH CARE PROVIDERS, RESERVING ANY AND ALL RIGHTS THEY HAVE AGAINST SAID HEALTH CARE PROVIDERS IN THEIR CAPACITY AS QUALIFIED HEALTH CARE PROVIDERS UNDER THE LOUISIANA MALPRACTICE ACT, THE STATE OF LOUISIANA, HON. DOUGLAS GREEN, COMMISSIONER OF INSURANCE AND THE LOUISIANA PATIENTS' COMPENSATION FUND; AND FOR DECLARATORY JUDGMENT FOR THE COURT TO DETERMINE THE AMOUNT OF THE CLAIMANTS' DAMAGES AND THE AMOUNT TO BE PAID FROM THE PATIENTS' COMPENSATION FUND, ALL PURSUANT TO La.R.S. 40:1299.44(c)

1.

The Petitioners are:

(1) WALLY EUGENE STUKA, husband of LORNA MARIE LARRIEU STUKA, a person of the full age of majority, and a resident of and domiciled in the Parish of Caddo, State of Louisiana, residing at 9470 Poinsetta Drive, Shreveport, LA 71118.

(2) LORNA MARIE LARRIEU STUKA, wife of WALLY EUGENE STUKA, a person of the full age of majority, and a resident of and domiciled in the Parish of Caddo, State

of Louisiana, residing at 9470 Poinsetta Drive, Shreveport, LA 71118.

2.

The Original Defendants in this cause are:

(1) DR. MICHAEL O. FLEMING, 2205 East 70th Street, Shreveport, LA 71105;

(2) DR. MARION CASH, 2205 East 70th Street, Shreveport, LA 71105.

(3) DR. RICKY L. JONES, 2205 East 70th Street, Shreveport, LA 71105.

3.

Added as additional Defendants in this cause are:

(1) MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION), 2205 East 70th Street, Shreveport, Louisiana, 71105, who can be served through its agents for service of process, Dr. Michael O. Fleming, 2205 East 70th Street, Shreveport, Louisiana, 71105, Telephone: 797-6661 or Dr. Ricky L. Jones, 2205 East 70th Street, Shreveport, Louisiana, 71105, Telephone: 797-6661.

(2) ST. PAUL FIRE AND MARINE INSURANCE COMPANY, medical malpractice insurer of the Health Care Providers, DR. MICHAEL O. FLEMING, DR. MARION N. CASH, DR. RICKY L. JONES and MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION).

(3) STATE OF LOUISIANA, to be served through the Governor, Hon. BUDDY ROEMER.

(4) HON. DOUG GREEN, COMMISSIONER OF INSURANCE, for the State of Louisiana, in his capacity as such, Manager and Representative of the PATIENTS' COMPENSATION FUND.

4.

That WALLY EUGENE STUKA and LORNA MARIE LARRIEU STUKA were married on July 13, 1985, and of their union one (1) child was born; namely, WALLY ANTHONY STUKA on March 30, 1986.

5.

That LORNA MARIE LARRIEU STUKA was under the care of the Defendant-Doctors for many years prior to the incident arising herein. LORNA MARIE LARRIEU STUKA was under the care of DR. MICHAEL FLEMING and went to see him on September 6, 1985 for sinus problems. He made a physical examination and prescribed medication.

6.

Petitioner, LORNA MARIE LARRIEU STUKA, saw DR. MICHAEL FLEMING again on November 15, 1985, and she again complained of headaches and sinus problems; DR. MICHAEL FLEMING examined her and prescribed medication.

7.

Petitioner, LORNA MARIE LARRIEU STUKA, had been seeing a Dr. Daigle, who had confirmed on August 21, 1985, that she was pregnant, and she continued to see Dr. Daigle and saw him on September 14 and on October 23, 1985, at which time a sonogram [sic] was performed by Dr. Daigle. Since she was seeing DR. MICHAEL FLEMING for her sinus problems, she decided to let DR. MICHAEL FLEMING handle the pregnancy and to deliver her baby. She saw DR. MICHAEL FLEMING on November 26, 1985, for her first OB Visit with him. An examination was performed, but no tests were given and Petitioner was informed by DR. MICHAEL FLEMING that he would send and get her chart from Dr. Daigle. It was on this date that she made her first $100.00 payment on her pregnancy.

8.

Petitioner, LORNA MARIE LARRIEU STUKA, saw DR. MICHAEL FLEMING on December 18, 1985, for an OB Visit and check-up and she made another $100.00 payment on this visit. She told DR. MICHAEL FLEMING that she was continuing to have headaches.

9.

On January 17, 1986, she saw DR. MICHAEL FLEMING and paid him $200.00 and he did a check-up on her. She told him that the headaches were continuing and they were getting more severe. At that time he did a neurological examination by turning the lights out and

having her look at a small light across the room. She informed him that she was continuing to have nausea. DR. MICHAEL FLEMING informed her that the nausea was related to her pregnancy. He prescribed Tylenol Extra Strength and told Petitioner to take it every four (4) hours.

10.

Petitioner, LORNA MARIE LARRIEU STUKA, saw DR. MICHAEL FLEMING on February 12, 1986, and paid him $150.00 for the OB Visit and check-up. She told him she was continuing to have headaches and they were growing increasingly worse and asked him if he was sure they were caused by the pregnancy. DR. MICHAEL FLEMING told her to use hot compresses and she would probably have the headaches for the duration of the pregnancy. He again examined her eyes and nose at that time.

11.

On February 24, 1986, the Petitioner again saw DR. MICHAEL FLEMING and at this time she came in specifically about the headaches she was having. They were severe and she was now having watering from her eye. No tests were performed on this occasion and DR. MICHAEL FLEMING told Petitioner it was still migrain [sic] headaches related to her pregnancy. He informed her that he as going to be out of town and he would refer her to DR. MARION CASH and DR. RICKY JONES.

12.

On March 3, 1986, Petitioner went in to see DR. MICHAEL FLEMING, but was referred to DR. MARION CASH. She paid $25.00. She informed DR. MARION CASH that she had been seeing DR. MICHAEL FLEMING and the headaches were getting progressively worse and at that time they were very severe and she was having a hard time going to work. She questioned whether the headaches were really related to her pregnancy and thought it might be something else. He agreed with her and said it might be so and prescribed Kelflex for her to take.

13.

The treatment rendered by DR. MICHAEL O. FLEMING during his care of Plaintiff appears to have been in accordance with accepted procedures, in that Plaintiff has suffered chronic sinus infection because of allergies and, by history, had been successfully treated medically with an antibiotic in the past. The treatment rendered by DR. MARION O. CASH on March 3, 1986, also appears to have been in accordance with accepted medical procedures when he saw her on that occasion. When, however, Plaintiff returned on March 13, 1986, and saw DR. RICKY L. JONES and was continuing to have severe headaches, the medications given by Drs. Fleming and Cash, were obviously not working and she was now throwing up several times a day. The standard of care for treatment of such a condition as presented by Plaintiff on that day by record, personal history and physical examination mandated application of nasal decongestants and

other appropriate procedures to insure sinus drainage, X-rays be taken to determine the air-fluid level in her frontal sinus, culture to insure the appropriateness of the prescribed antibiotic, and referral to an expert such as an otolaryngologist for treatment of her condition, which among other things would have been drainage of all the sinuses and hospitalization for the administration of parental antibiotics. DR. JONES, in failing to do so, violated the appropriate standard of care and such negligence was the proximate cause of Plaintiff's subsequent disability and damages.

14.

On March 18, 1986, Plaintiff again went in to see DR. RICKY L. JONES and her condition was getting progressively worse. On this occasion, by history and physical examination, she was continuing to have severe, unrelenting headaches and was throwing up constantly; in fact, she threw up in the presence of DR. RICKY L. JONES. DR. JONES gave her a shot. He again failed to take any X-rays to determine the air-fluid of the frontal sinus. He again was negligent when he failed to administer nasal decongestants to clear the maxillary sinus to perfect drainage of the frontal sinus, to take X-rays to determine the air-fluid level of the frontal sinus and to hospitalize her for the administration of parental antibiotics, or refer her to an expert otolaryngologist for appropriate consultation and treatment. DR. RICKY L. JONES'S negligence on this occasion was a proximate cause of Plaintiff's resulting injuries and damages. On this occasion, instead of following the prescribed treatment in accordance with the standard of care appropriate to

Plaintiff's history and condition, DR. RICKY L. JONES, told Plaintiff she was having cluster headaches and changed her medications to Demerol and gave her a shot, telling Plaintiff that it would break the pain chain.

15.

On March 19, 1986, when the Petitioner's husband, WALLY EUGENE STUKA, came home from work to check on her and perhaps take her to the Doctor, he found her still to be in bed and worse. Her husband called at 4:30 o'clock P.M. and was told by the Nurse that DR. MARION CASH and DR. RICKY JONES had already gone for the day. The Petitioners left their home telephone number; as Petitioner, WALLY EUGENE STUKA, was leaving the home number and telling the Nurse how bad LORNA MARIE LARRIEU STUKA'S headaches were, DR. MARION CASH, who was supposedly not there, got on the telepone [sic]. Petitioner, WALLY EUGENE STUKA, again explained the symptoms that LORNA MARIE LARRIEU STUKA had been having and the terrible headaches. Petitioner, LORNA MARIE LARRIEU STUKA, was very weak and she could not keep anything on her stomach – not even water. Now she was so weak she could not even get out of bed. The Petitioner was prescribed suppositories by phone.

16.

The medication in the nature of suppositories was obtained and they did help in allowing Petitioner to keep some fluids down, but the next day on March 20, 1986,

Petitioner continued to have pain and was getting progressively weaker. When the Petitioner called for an appointment, the Nurse informed Petitioner to come in, "in the morning." Petitioner was up all that night. The next morning, on March 21, 1986, the Petitioner's Father came to take her to the Doctor; the Petitioner was having difficulty staying awake. The Petitioner was taken to the Schumpert Medical Center and admitted at 1:23 o'clock P.M. and was diagnosed as having, "brain abscess in the right frontal lobe." Surgery was performed for "drainage and excision of the right frontal lobe abscess, emergency right frontal craniotomy." She was found to have infection in her right sinus.

17.

Petitioner, LORNA MARIE LARRIEU STUKA, was admitted by DR. MARION CASH, whose impression on admission was:

(1) Recurrent sinusitis associated with nausea, vomiting, and dehydration.

(2) Pre-eclampsia.

(3) Central nervous system lesion.

18.

At this time, Petitioner was thirty-six (36) weeks gestation.

19.

A Gynecologist was called in for consultation and after examination ruled out the pre-eclampsia; and, a

Neurosurgeon was called in for consultation the following day on March 22, 1986, whose impression was as follows:

(1) Acute right frontal cerebritis with early formation of an abscess.

(2) Postictal, secondary to generalized seizure.

(3) Increased intracranial pressure, secondary to the acute cerebritis.

20.

The right front temporal craniotomy was performed on March 22, 1986, and revealed a right frontal lobe abscess with rupture and adherence to surrounding fibers and osseous structures. The abscess capsule was removed; the frontal sinus communicated with cranial cavity and the posterior wall of the right frontal sinus was grossly necrotic. The right frontal sinus was debrided.

21.

The Petitioner, LORNA MARIE LARRIEU STUKA, underwent aspiration and irrigation of the right maxillary sinus on subsequent days. She also underwent an emergency Cesarean Section on March 30, 1986.

22.

The Petitioner, LORNA MARIE LARRIEU STUKA, now suffers some permanent seizure disorders and other related brain damages.

23.

Petitioners show that had DR. RICKY L. JONES followed the standard of care and treated Petitioner appropriately the sinus condition could have been treated and more probably than not the erosion of the infection to the cranial cavity causing the brain abscess could have been prevented.

24.

Petitioners respectfully show that the failure of DR. RICKY L. JONES to do the following resulted in treatment and care below the standard of care for the specialty of family medicine practice and proximately caused the injuries and damages complained of herein:

(1) Administer decontgestants [sic];

(2) Open up drainage of the sinus;

(3) Run cultures to determine if the antibiotics were appropriate;

(4) To have x-rays and tests made to determine air-fluid level;

(5) To refer her to an expert otolaryngologist;

(6) To hospitalize her;

(7) To do a CT scan to evaluate headaches which continued to be progressively worse.

(8) He was negligent in failing to timely respond to LORNA MARIE LARRIEU STUKA'S condition and give immediate attention to the diagnosis and treatment of her condition, i.e. headaches and sinusitis which ultimately resulted in LORNA MARIE LARRIEU STUKA having a brain abscess.

(9) He was negligent in failing to exercise the degree of skill and care ordinarily exercised by other physicians engaged in the practice of the medical speciality of a family medicine practitioner.

Each of these deletions in treatment represented in and of itself sub-standard care that falls below the standard of care for a family medicine practitioner.

25.

Petitioners respectfully show that the principles of res ipsa loquitur are applicable to the present situation as an alternative pleading in that:

(1) The accident or injury that LORNA MARIE LARRIEU STUKA underwent normally does not occur in the absence of negligence;

(2) There exist an absence of direct evidence to explain the activities leading up to her injuries, damages and surgery;

(3) The accident, injuries, damages and surgery resulting from the administration of the treatment was caused by an agency or instrumentality within the actual or constructive control of the Defendants.

26.

That Defendant, DR. RICKY L. JONES, Individually and as the agent and employee of Defendant, MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION), knew or should have known that the treatment of the Plaintiff, LORNA MARIE LARRIEU STUKA,

was not done in the accepted method and that subsequent thereto the treatment ordered was inappropriate for Plaintiff's condition.

27.

At all material times referenced in this petition, particularly on the date of the incident giving rise to this instant lawsuit, the agent and employee of the Defendant, MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION), particularly those Physicians who treated Plaintiff, LORNA MARIE LARRIEU STUKA, namely DR. RICKY L. JONES on March 13th and 18th, 1986, was acting in the scope of their employment at the time of the incident and as such Defendant, MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION) is responsible for any acts, particularly acts of negligence and medical malpractice causing damage to the Petitioner under the principles of respondeat superior, as fully as if Defendant, MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION) had committed the said acts of negligence itself.

28.

At all material times herein the Health Care Providers, DR. RICKY JONES and MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION) were covered under a professional liability insurance policy issued by ST. PAUL FIRE AND MARINE INSURANCE COMPANY, covering periods when this incident occurred, more particularly March 13-21, 1986.

29.

That DR. RICKY L. JONES and the Corporation, MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION), were qualified under the Louisiana Medical Malpractice Act, *La.R.S. 40:1299.41, et seq.*

30.

The Health Care Providers in this case are all Family Practitioners and they operate their business in regard to the public as follows:

"Family Practice

Michael O. Fleming, M.D.
Ricky L. Jones, M.D.
Marion N. Cash, M.D.
A Medical Corporation
The Medical Plaza
2205 E. 70th Street
Shreveport, LA 71105
Phone (318) 797-6661"

31.

The legal relationship among the Doctors, qualified Health Care Providers in this case, is that there is a corporation known as, "MICHAEL O. FLEMING AND RICKY L. JONES (A PROFESSIONAL MEDICAL CORPORATION)" and the said Defendants, DR. MICHAEL O. FLEMING, DR. RICKY L. JONES and DR. MARION N. CASH, were employees at all material times of the said corporation, MICHAEL O. FLEMING AND RICKY L. JONES (A PROFESSIONAL MEDICAL CORPORATION).

32.

The Plaintiffs and the Health Care Providers, MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION), DR. RICKY L. JONES, and their Insuror [sic], desire to settle their case and have reached an agreement, whereby the Health Care Provider will pay the sum of ONE HUNDRED THOUSAND & NO/100 ($100,000.00) DOLLARS.

33.

The Plaintiffs-Claimants have agreed to accept the $100,000.00, but are asserting and demanding payment of damages in excess thereof from the Louisiana PATIENTS' COMPENSATION FUND in an amount of $400,000.00, plus legal interest on the total of $500,000.00 from the date of February 20, 1987, when the Medical Review Panel was envoked [sic], until paid, plus all costs including expert witness fees and future medical, as appropriate.

34.

The Plaintiffs and the Insuror [sic], as well as the Health Care Provider, MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION) and DR. RICKY L. JONES have reached an agreement whereby the Plaintiffs-Claimants would release the said qualified Health Care Providers, MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION) and DR. RICKY L. JONES and their professional liability insurance carrier, ST. PAUL FIRE & MARINE INSURANCE

COMPANY, insofar as any "individual" liability is concerned, reserving rights against same in their capacity as a qualified Health Care Provider and/or any of its agents and employees, and while reserving their rights to seek additional damages from the STATE OF LOUISIANA, COMMISSIONER OF INSURANCE, and the PATIENTS' COMPENSATION FUND.

35.

The Plaintiffs show that the duties of the COMMISSIONER OF INSURANCE are to collect the monies and to administer the Fund. *La.R.S. 40:1299.44(A)(5), et seq.*

36.

The Louisiana PATIENTS' COMPENSATION FUND is a special fund of the State Treasury characterized by Statute as a "Budget Unit" of the STATE OF LOUISIANA. *La.R.S. 40:1299.44(A)(5)(g).*

37.

The Plaintiffs show that a copy of this petition should be served on the COMMISSIONER OF INSURANCE, HON. DOUG GREEN, through the Sheriff of East Baton Rouge Parish, Louisiana.

38.

That a True Copy of this petition with the proposed Judgment has been sent to:

(1) Hon. Douglas Green, Commissioner of Insurance,
Insurance Building, State Capitol
P.O. Box 44214
Baton Rouge, Louisiana 70804

(2) Louisiana Patients' Compensation Fund
c/o its Attorneys
Mr. William R. Carruth, Jr.
Carruth, Cooper & Adams
Attorneys at Law
4000 S. Sherwood Forest Blvd., Suite 500
Baton Rouge, LA 70816

39.

The Plaintiffs have agreed to dismiss DR. MICHAEL O. FLEMING, individually, and DR. MARION N. CASH, individually, with prejudice. The Plaintiffs will dismiss MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION) and DR. RICKY L. JONES in accordance with the terms of this Petition and Release, reserving all rights against them and the Louisiana PATIENTS' COMPENSATION FUND for additional damages.

40.

That the Plaintiffs will dismiss MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION) and DR. RICKY L. JONES, as warranted by the evidence, from the litigation except insofar as it is necessary that they remain nominal parties for the purposes of prosecuting the claim against the Louisiana PATIENTS' COMPENSATION FUND.

41.

That the Plaintiffs expressly reserve their rights to pursue their claim against the Louisiana PATIENTS' COMPENSATION FUND, in accordance with Louisiana law.

42.

That, in order for Plaintiffs to reserve their rights against the PATIENTS' COMPENSATION FUND, it is necessary that the procedures set forth in *La.R.S. 40:1299.44C* be followed and that this petition be submitted to the Court for approval of the proposed settlement as required by the Statute.

43.

DR. MICHAEL O. FLEMING, DR. RICKY L. JONES, DR. MARION N. CASH, MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION) and ST. PAUL FIRE AND MARINE INSURANCE COMPANY, through their undersigned counsel, do hereby waive the requirement that this petition be served on them at least ten (10) days before filing and hereby waive any requirement that the approval of this settlement be scheduled for a hearing.

44.

The COMMISSIONER OF INSURANCE of the State of Louisiana has offered no Opinion on the $100,000.00 settlement between Plaintiffs and Defendant, MICHAEL

O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION) and DR. RICKY L. JONES.

45.

DR. MICHAEL O. FLEMING, DR. RICKY L. JONES, DR. MARION N. CASH, MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION), and ST. PAUL FIRE AND MARINE INSURANCE COMPANY, through their undersigned counsel, hereby concur in the settlement.

WHEREFORE, Petitioners pray:

(1) THAT the proposed settlement be approved, reserving unto Petitioners their claim against the Louisiana PATIENTS' COMPENSATION FUND.

Respectfully submitted,

/s/ Don Miller
DONALD R. MILLER APLC
725 SLATTERY BUILDING
SHREVEPORT, LA 71101
(318) 222-9417

ATTORNEY FOR PETITIONERS,
WALLY EUGENE STUKA &
LORNA MARIE LARRIEU STUKA.

SERVICE INSTRUCTIONS:

PLEASE SERVE HON. D0UG GREEN, COMMISSIONER OF INSURANCE, THROUGH THE SHERIFF OF EAST BATON ROUGE, LOUISIANA, AT INSURANCE BUILDING, STATE CAPITOL, BATON ROUGE, LA 70804.

WALLY EUGENE STUKA & LARRIEU STUKA	§	LORNA MARIE NUMBER: 330,930
VERSUS	§	FIRST JUDICIAL DISTRICT COURT
DR. MICHAEL FLEMING, ET AL	§	CADDO PARISH, LOUISIANA

ASSIGNED TO: JUDGE HAMILTON

CONCURRENCE

I, the undersigned attorney for DR. MICHAEL O. FLEMING, DR. RICKY L. JONES, DR. MARION N. CASH, MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION) and ST. PAUL FIRE AND MARINE INSURANCE COMPANY, hereby waive the requirements of service and the necessity of any hearing required for approval of this settlement as provided in *LSA-R.S. 40:1299.44C* and *hereby concur in the terms and conditions of the proposed settlements;* however, this settlement is not to be considered an admission of liability on the part of the above-referenced Health Care Providers and their malpractice insurance company, ST. PAUL FIRE AND MARINE INSURANCE AND COMPANY, by whom liability is expressly denied, except insofar as the provisions of *La.R.S. 40:1299.44C(5)* are concerned.

MAYER, SMITH & ROBERTS
Attorneys at Law

By: /s/ Caldwell Roberts
CALDWELL ROBERTS

1550 Creswell Avenue
Shreveport, LA 71101

ATTORNEYS FOR DR.
MICHAEL O. FLEMING,

DR. RICKY L. JONES, DR. MARION N. CASH, MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION) and ST. PAUL FIRE AND MARINE INSURANCE COMPANY

WALLY EUGENE STUKA & LORNA MARIE LARRIEU STUKA	§	NUMBER: 330,930
VERSUS	§	FIRST JUDICIAL DISTRICT COURT
DR. MICHAEL FLEMING, ET AL	§	CADDO PARISH, LOUISIANA
ASSIGNED TO: JUDGE HAMILTON		

MOTION PURSUANT TO LA. R. S. 40:1299.44C(4) TO FIX DATE FOR HEARING ON PLAINTIFFS' PETITION SEEKING APPROVAL OF AN AGREED UPON SETTLEMENT AND TO DETERMINE PLAINTIFF'S DAMAGES, IF ANY, TO BE PAID FROM THE LOUISIANA PATIENTS' COMPENSATION FUND

The Petitioners, WALLY EUGENE STUKA and LORNA MARIE LARRIEU STUKA, respectfully show:

1.

That the Petitioners and Defendants, DR. RICKY L. JONES and MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION) and their insurer, ST. PAUL FIRE AND MARINE INSURANCE COMPANY, have reached an agreement under the provisions of *La. R. S. 40:1299.44, et seq,* wherein the health care provider is going to pay $100,000.00 for a restricted release, reserving rights against the LOUISIANA PATIENTS' COMPENSATION FUND for additional damages;

2.

That suit was served on Defendants on July 28, 1988, by certified mail per #P-563 272 982, which was ten (10) days before the filing of suit on August 10, 1988, seeking approval of this settlement and demanding damages in excess thereof from the LOUISIANA PATIENTS' COMPENSATION FUND. Attached and made a part hereof as if copied in extenso, are the following:

a. *Attachment #1* letter dated July 28, 1988 to Hon. Doug Green by Certified Mail, Return Receipt Requested, #P-563 272 982;

b. *Attachment* #2 Green card of the Return Receipt Requested showing receipt by "S. Hulbert" of #P-563 272 982 on August 1, 1988;

c. *Attachment* #3 letter dated August 1, 1988, from Emery J. Bares, Deputy Commissioner, Medical Malpractice to Donald R. Miller, Attorney, acknowledging receipt of July 28, 1988 letter and amended petition.

3.

That the Plaintiffs-Claimants waited ten (10) days after the petition was served on the Commissioner of Insurance before filing their first supplemental and amending petition in Court on August 10, 1988.

4.

That more than twenty (20) days have elapsed since the filing of the petition and neither the Commissioner of Insurance nor the insurer of the Health Care Provider have filed written objections to the payment of the amount demanded in Plaintiffs' petition, as will be more fully shown by the attached Certificate from the Clerk of

Court that no objection has been filed as of September 1, 1988.

5.

The Plaintiffs, in accordance with Paragraph 4 of *La. R. S. 40:1299.44C(4)*, request that the Court set a time for a hearing to determine whether or not to approve the agreed upon settlement and authorize the Plaintiff and Health Care Provider to go ahead and proceed with the settlement with the restricted release and to set a time when the Court would hear the evidence to determine what amount, if any, shall be paid from the LOUISIANA PATIENTS' COMPENSATION FUND.

6.

The Plaintiffs further request that the Court notify the Commissioner of Insurance, the Health Care Provider and its insurer of the date of the hearing as provided by law.

WHEREFORE, PETITIONERS PRAY:

That the Court set a hearing date when this Court shall determine whether or not to approve the agreed upon settlement and authorize the Plaintiff and Health Care Provider to go ahead and proceed with the settlement with the restricted release and to set a time when the Court would hear the evidence to determine what amount, if any, shall be paid from the LOUISIANA PATIENTS' COMPENSATION FUND.

/s/ Don Miller
DONALD R. MILLER APLC
725 SLATTERY BUILDING
SHREVEPORT, LA 71101
(318) 222-9417

ATTORNEY FOR PETITIONERS.

SERVICE INSTRUCTIONS TO THE CLERK OF COURT:

1) Mr. Caldwell Roberts
Atty for Michael O. Fleming, et al
Mayer, Smith & Roberts
Attorneys at Law
1550 Creswell Avenue
Shreveport, Louisiana 71101

2) Hon. Doug Green
Commissioner of Insurance
Insurance Building, State Capitol
P.O. Box 44214
Baton Rouge, Louisiana 70804

Attachment 1

P-563 272 962
RECEIPT FOR CERTIFIED MAIL
NO INSURANCE COVERAGE PROVIDED
NOT FOR INTERNATIONAL MAIL
(See Reverse)

Sent to Hon. Doug Green
Commissioner of Insurance
Insurance Building, Sta
P.O. Box 44214
Baton Rouge, Louisiana

Postage $

Certified Fee

Special Delivery Fee

Restricted Delivery Fee

Return Receipt showing to whom and Date Delivered

Return Receipt showing to whom, Date and Address of Delivery

TOTAL Postage and Fees $

Postmark or Date

PS Form 3800, June 1985 U.S.G.P.O. 153-506

Donald R. Miller
A PROFESSIONAL LAW CORPORATION
SUITE 725 SLATTERY BLDG.
SHREVEPORT, LOUISIANA 71101

DONALD R. MILLER
July 28, 1988

CERTIFIED MAIL: Return Receipt Requested

Hon. Doug Green
Commissioner of Insurance
Insurance Building, State Capitol
P.O. Box 44214
Baton Rouge, Louisiana 70804

IN RE: Our client WALLY EUGENE STUKA & LORNA MARIE LARRIEU STUKA – PETITION TO IMPANEL MEDICAL REVIEW PANEL AND FOR DAMAGES WALLY EUGENE STUKA & LORNA MARIE LARRIEU STUKA VS. DR. MICHAEL FLEMING, ET AL, #330, 930, 1st Judicial District Court, Caddo Parish, Louisiana Assigned to Judge Hamilton

Dear Sir:

Pursuant to *La.R. S. 40:1299.44 (C)*, please find enclosed a true copy of the following pleadings:

(1) ORIGINAL PETITION (filed 2/20/87)

(2) FIRST SUPPLEMENTAL AND AMENDING PETITION OF PLAINTIFFS-CLAIMANTS FOR PERMISSION TO OBTAIN APPROVAL OF SETTLEMENT WITH QUALIFIED HEALTH CARE PROVIDERS, RESERVING ANY AND ALL RIGHTS THEY HAVE AGAINST SAID HEALTH CARE PROVIDERS IN THEIR CAPACITY AS QUALIFIED HEALTH CARE PROVIDERS UNDER THE LOUISIANA MALPRACTICE ACT, THE STATE OF LOUISIANA, HON. DOUGLAS GREEN, COMMISSIONER OF INSURANCE AND THE LOUISIANA PATIENTS' COMPENSATION FUND; AND FOR DECLARATORY JUDGMENT FOR THE COURT TO DETERMINE THE AMOUNT OF THE CLAIMANTS' DAMAGES AND THE AMOUNT TO BE PAID FROM THE PATIENTS' COMPENSATION FUND, ALL PURSUANT TO La.R.S. 40:1299.44(c) (to be filed 10 days from the date hereof) with attached CONCURRENCE executed by Mr. Caldwell Roberts with attached proposed JUDGMENT OF APPROVAL with attached proposed RECEIPT AND RELEASE.

Best regards, I remain,

Very truly yours,

/s/ Donald R. Miller
DONALD R. MILLER APLC

DM:td/encls.

cc: Mr. William R. Carruth, Jr., Attorney for Patients' Compensation Fund (copy sent with courtesy copy original and supplemental pleadings)

cc: Mr. Jerry Perlman, Attorney (copy sent with courtesy copy of original and supplemental pleadings)

cc: Mr. Caldwell Roberts, Attorney

cc: Hon. Andrew Gallagher, Legal Adviser to the Medical Review Panel

cc: Mr. and Mrs. Wally Stuka

Attachment 2

SENDER: Complete items 1 and 2 when additional services are desired, and complete items 3 and 4.

Put your address in the "RETURN TO" Space on the reverse side. Failure to do this will prevent this card from being returned to you. *The return receipt fee will provide you the name of the person delivered to and the date of delivery.* For additional fees the following services are available. Consult postmaster for fees and check box(es) for additional service(s) requested.

1. ___ Show to whom delivered, date, and addressee's address.

↑*(Extra charge)*↑

2. ___ Restricted Delivery

↑*(Extra charge)*↑

3. Article Addressed to:
Hon. Doug Green
Commissioner of Insurance
Insurance Building, State Capitol
P.O. Box 44214
Baton Rouge, Louisiana 70804

4. Article Number
P-563-272-982

Type of Service:

___ Registered	___ Insured
✓ Certified	___ COD
___ Express Mail	

Always obtain signature of addressee or agent and DATE DELIVERED.

5. Signature – Addressee
X

6. Signature – Agent
X /s/ S. Hulbert

7. Date of Delivery
AUG 1 1988

8. Addressee's Address *(ONLY if requested and fee paid)*

8/3/88 rec'd

*U.S.G.P.O. 1987-178-268
PS Form 3811, Mar. 1987 DOMESTIC RETURN RECEIPT

Attachment 3

STATE OF LOUISIANA

Commissioner of Insurance
P.O. BOX 94214
BATON ROUGE 70804-9214

Douglas B. "Doug" Green
Commissioner

CERTIFIED MAIL
RETURN RECEIPT REQUESTED August 1, 1988

Donald R. Miller, Esq.
Ste. 725 Slattery Bldg.
Shreveport, LA 71101

RE: Wally & Lorna Stuka VS Dr. Michael Fleming et al
Our File No: 87-163 Date Filed: 2/20/87

Dear Mr. Miller:

This will acknowledge receipt of your letter of July 28, 1988 submitting an amended petition in this matter.

A copy of your amendment is being forwarded to all parties involved in this matter.

Sincerely,

/s/ Emery J. Bares

Emery J. Bares
Deputy Commissioner
Medical Malpractice

EJB/dvc
cc: William Carruth, Atty. for PCF
Duke Truby (ST. PAUL)
Henry Gallagher, Atty. Chairman

8-3-88 rec'd

"An Equal Opportunity Employer"

WALLY EUGENE STUKA & LORNA MARIE

LARRIEU STUKA	§	NUMBER: 330,930
VERSUS	§	FIRST JUDICIAL
DR. MICHAEL FLEMING, ET AL	§	DISTRICT COURT
	§	CADDO PARISH,
	§	LOUISIANA

ASSIGNED TO: JUDGE HAMILTON

CERTIFICATE OF CLERK OF COURT ATTACHED TO MOTION PURSUANT TO LA. R. S. 40:1299.44C(4) TO FIX DATE FOR HEARING ON PLAINTIFFS' PETITION SEEKING APPROVAL OF AN AGREED UPON SETTLEMENT AND TO DETERMINE PLAINTIFFS' DAMAGES, IF ANY, TO BE PAID FROM THE LOUISIANA PATIENTS' COMPENSATION FUND THAT NO WRITTEN OBJECTIONS TO THE PAYMENT OF THE AMOUNT DEMANDED IN PLAINTIFFS' PETITION HAVE BEEN FILED TO DATE

THIS WILL CERTIFY THAT:

1. The pleading entitled FIRST SUPPLEMENTAL AND AMENDING PETITION OF PLAINTIFFS-CLAIMANTS for PERMISSION TO OBTAIN APPROVAL OF SETTLEMENT WITH QUALIFIED HEALTH CARE PROVIDERS, RESERVING ANY AND ALL RIGHTS THEY HAVE

AGAINST SAID HEALTH CARE PROVIDERS IN THEIR CAPACITY AS QUALIFIED HEALTH CARE PROVIDERS UNDER THE LOUISIANA MALPRACTICE ACT, THE STATE OF LOUISIANA, HON. DOUGLAS GREEN, COMMISSIONER OF INSURANCE AND THE LOUISIANA PATIENTS' COMPENSATION FUND; AND FOR DECLARATORY JUDGMENT FOR THE COURT TO DETERMINE THE AMOUNT OF THE CLAIMANTS' DAMAGES AND THE AMOUNT TO BE PAID FROM THE PATIENTS' COMPENSATION FUND, ALL PURSUANT TO La.R.S. 40:1299.44(c) was filed on August 10, 1988 and no written objections to the payment of the amount demanded in Plaintiffs' petition have been filed to date by the Commisisoner [sic] of Insurance nor the insurer of the Health Care Provider in the office of the Clerk of the First Judicial District Court, Caddo Parish, Louisiana and these proceedings.

2. That on August 15, 1988, a copy of same was served with a twenty-day citation on DR. MICHAEL O. FLEMING, DR. MARION CASH, DR. RICKY L. JONES, MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION) AND ST. PAUL FIRE AND MARINE INSURANCE COMPANY THROUGH CALDWELL ROBERTS, ATTORNEY OF RECORD and they have filed no written objections to date.

3. That on August 23, 1988, a copy of same was served with a twenty-day citation on STATE OF LOUISIANA THRU HON. BUDDY ROEMER, STATE CAPITOL, BATON ROUGE, LOUISIANA and he has filed no written objections to date.

4. That on August 19, 1988, a copy of same was served with a twenty-day citation on HON. DOUG GREEN, COMMISSIONER OF INSURANCE STATE OF LOUISIANA, IN HIS CAPACITY AS SUCH, MANAGER AND REPRESENTATIVE OF THE PATIENTS' COMPENSATION FUND @ INSURANCE BLDG., STATE CAPITOL, BATON ROUGE, LA and he has filed no written objectiosn [sic] to date.

SHREVEPORT, CADDO, PARISH, LOUISIANA, this the 1 day of SEPTEMBER, 1988.

/s/ Bob Schulman
DEPUTY CLERK

WALLY EUGENE STUKA & LORNA MARIE LARRIEU STUKA	§	NUMBER: 330,930
VERSUS	§	FIRST JUDICIAL DISTRICT COURT
DR. MICHAEL FLEMING, ET AL	§	CADDO PARISH, LOUISIANA

ASSIGNED TO: JUDGE HAMILTON

ORDER

(Filed Sept. 1, 1988)

CONSIDERING THE ABOVE AND FOREGOING MOTION,

IT IS ORDERED:

That this matter be set for hearing on the 14th day of September 1988, at 9:30 o'clock A.M. to determine whether or not to approve the agreed upon settlement and authorize the Plaintiff and Health Care Provider to go ahead and proceed with the settlement with the

restricted release and to set a time when the Court would hear the evidence to determine what amount, if any, shall be paid from the LOUISIANA PATIENTS' COMPENSATION FUND.

SHREVEPORT, CADDO PARISH, LA this the 1 day of SEPTEMBER, 1988.

/s/ Gayle K. Hamilton
DISTRICT JUDGE.

WALLY EUGENE STUKA & LORNA MARIE

LARRIEU STUKA	§	NUMBER: 330,930
VERSUS	§	FIRST JUDICIAL DISTRICT COURT
DR. MICHAEL FLEMING, ET AL	§	CADDO PARISH, LOUISIANA

ASSIGNED TO: JUDGE HAMILTON

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the above and foregoing MOTION PURSUANT TO LA. R. S. 40:1299.44C(4) TO FIX DATE FOR HEARING ON PLAINTIFFS' PETITION SEEKING APPROVAL OF AN AGREED UPON SETTLEMENT AND TO DETERMINE PLAINTIFFS' DAMAGES, IF ANY, TO BE PAID FROM THE LOUISIANA PATIENTS' COMPENSATION FUND has this the 1 day of September, 1988, been mailed to the following:

Mr. Caldwell Roberts
Mayer, Smith & Roberts
Attorneys at Law
1550 Creswell Avenue
Shreveport, LA 71101

- Mailed by Certified Mail Return Receipt Requested & Hand Delivered

Hon. Doug Green
Commissioner of Insurance
Insurance Building,
State Capitol
P.O. Box 44214
Baton Rouge, LA 70804

- Mailed by Certified Mail Return Receipt Requested

/s/ Don Miller
COUNSEL

WALLY EUGENE STUKA & LORNA MARIE LARRIEU STUKA § NUMBER: 330,930
§
VERSUS §
§ FIRST JUDICIAL
§ DISTRICT COURT
DR. MICHAEL FLEMING, §
ET AL §
§ CADDO PARISH,
§ LOUISIANA

ASSIGNED TO: JUDGE HAMILTON

JUDGMENT OF APPROVAL

CONSIDERING the foregoing petition; having been informed of the facts and circumstances surrounding the matter and being of the opinion that the settlement is fair and proper in accordance with the provisions of LSA-R.S. 40:1299.44C:

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the proposed settlement be approved and that Defendants, MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION), DR. RICKY L. JONES, and ST. PAUL FIRE AND MARINE INSURANCE COMPANY be authorized to pay the sum of ONE HUNDRED & NO/100 ($100,000.00) DOLLARS to Petitioners, WALLY EUGENE STUKA and LORNA MARIE LARRIEU STUKA, in full and final settlement of any and all claims against MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION), DR. RICKY L. JONES, and their insurer, ST. PAUL FIRE AND MARINE INSURANCE COMPANY, which they have or may in the future have as a result of the incident, reserving unto Petitioners any and all claims which they may have against the DR. RICKY L. JONES, MICHAEL O. FLEMING AND RICKY L. JONES (A MEDICAL CORPORATION), its agents and employees, and/or the Louisiana Patients' Compensation

Fund, but only to the extent necessary to preserve Petitioners' rights against the Louisiana Patients' Compensation Fund.

Any and all rights or claims of Petitioners against DR. MICHAEL O. FLEMING, individually, DR. MARION N. CASH, individually, and the ST. PAUL FIRE & MARINE INSURANCE COMPANY, are dismissed with prejudice.

THUS DONE AND SIGNED in Shreveport, Caddo Parish, Louisiana, this the 14 day of September, 1988.

/s/ Gayle K. Hamilton
DISTRICT JUDGE.

		SUITE NO. 330,930
WALLY EUGENE STUKA, LORNA MARIE & LARRIEU STUKA	*	1ST JUDICIAL DISTRICT COURT
VERSUS	*	PARISH OF CADDO
DR. MICHAEL FLEMING, ET AL	*	STATE OF LOUISIANA

ANSWER

(Filed Sept. 15, 1988)

NOW INTO COURT, through undersigned counsel, comes the Office of the Commissioner Of Insurance of the State of Louisiana, the Office of the Attorney General of the State of Louisiana, and the Louisiana Patient's Compensation Fund, purportedly made defendants herein, and in response to the allegations of plainitff's [sic] original and amended petitions, and claim for an amount of damages to be paid from the Patient's Compensation Fund. respectfully represent:

1.

Respondents deny each and every allegation contained in the original and supplemental and amended petitions filed by the claimants for lack of sufficient information to justify a belief therein.

FURTHER responding to the plaintiff's petitions, respondents respectfully represent:

2.

Plaintiffs have sued four defendant health care providers in this case. Those defendants are Dr. Michael O.

Fleming, Dr. Marion Cash, Dr. Ricky L. Jones and Michael O. Fleming and Ricky L. Jones (A Medical Corporation). Allegations of medical negligence have been raised against these defendants.

3.

Plaintiff have now reached a settlement agreement with the defendant health care providers, whereby the defendant health care providers and their insurer will pay a total of $100,000.00 in settlement, and the plaintiffs will reserve their rights to proceed in their claim for excess damages against the Louisiana Patient's Compensation Fund.

4.

It is submitted that the settlement described above wherein four health care providers are released in consideration of a payment of $100,000.00 does not constitute an admission of liability under the provisions of La. R.S.40:1299.44C(5). Consequently, all issues, including the issues of whether there was a breach of the standard of care, how many, if any, of the health care providers breached the standard of care, and the amount of the damages owed as a result of any proven breach of the standard of care are still at issue and must all be litigated to conclusion.

5.

Respondents have denied and continue to deny that any of the health care providers breached the appropriate

standard of care in their treatment of petitioner, Lorna Marie Larrieu Stuka.

6.

In the alternative, and only in the event that this court determines that any of the health care providers did in fact breach the appropriate standard of care, the office of the Commissioner of Insurance, the office of the Attorney General of the State of Louisiana, and the Louisiana Patient's Compensation Fund claim and are entitled to the provisions of the Louisiana Medical Malpractice Act, La. R.S.40:1299.41, et seq, particularly La. R.S. 40:1299.42B.

7.

In the further alternative, respondents represent that petitioner damages, if any, do not exceed the total liability of all health care providers who will or may be found to be at fault in this case.

8.

Respondents offer no opinion whatsoever on the proposed settlement which petitioners desire to present for approval and which, upon information and belief, respondents believe is scheduled approved by this Court on or about September 14, 1988. However, respondents have denied and continue to deny that this proposed settlement in any way activates the provisions of La. R.S.40:1299.44C(5).

9.

Respondents pray for trial by jury on all issues.

WHEREFORE, respondents pray that this Answer be deemed good and sufficient and, after due proceedings, that petitioners claims be dismissed at petitioners cost.

Respectfully submitted:

CARRUTH, COOPER AND ADAMS
A LAW CORPORATION

BY: /s/ Ambrose K. Ramsey, III
AMBROSE K. RAMSEY, III
4000 S. Sherwood Forest Blvd.
Suite 500
Baton Rouge, LA 70816
504/295-1755

CERTIFICATE

I hereby certify that a copy of the above and foregoing has been mailed to all known counsel of record, properly addressed and with proper postage affixed, on this 12th day of September, 1988 Baton Rouge, Louisiana /s/ Ambrose K. Ramsey, III.

WALLY EUGENE STUKA & LORNA MARIE LARRIEU STUKA

VERSUS	§	NUMBER: 330,930
DR. MICHAEL FLEMING, ET AL	§	FIRST JUDICIAL DISTRICT COURT
	§	CADDO PARISH, LOUISIANA

ASSIGNED TO: JUDGE HAMILTON

MOTION TO STRIKE PURSUANT TO LSA-C.C.P. ARTICLE 964; AND OPPOSITION TO DEFENDANT DOUGLAS D. "DOUG" GREEN LOUISIANA COMMISSIONER OF INSURANCE'S EXCEPTION OF NO CAUSE OF ACTION & EXCEPTION OF VAGUENESS

(Filed Oct. 3, 1988)

The Petitioners, WALLY EUGENE STUKA and LORNA MARIE LARRIEU STUKA, respectfully show:

1.

That the Petitioners object to the Exception of No Cause of Action filed by the Defendant, Douglas D. "Doug" GREEN, COMMISSIONER OF INSURANCE AND AS ADMINISTRATOR OF THE Louisiana Patient's Compensation Fund, hereinafter referred to as "Commissioner."

2.

That the Petitioners initially filed suit and petitioned to invoke a Medical Review Panel on February 20, 1987.

3.

That copies of all medical bills and medical records of Plaintiffs-Claimants were furnished to the Insurance Commissioner, through his counsel on on [sic] May 25, 1988.

4

Subsequent to discovery, including interrogatories and answers, depositions, and extensive conferences between counsel for Plaintiffs-Claimants and Defendants-Doctors and their malpractice insuror, ST. PAUL INSURANCE COMPANY, a decision was reached that for the mutual benefit of all concerned, the procedures of LSA-R.S. 40:1299.44C (hereinafter referred to as the Act) would be utilized, as it was determined that only one of the named Health Care Providers was subject to Plaintiff-Claimants contentions. Agreement was reached to dismiss those Health Care Providers not involved and proceed with a settlement pursuant to LSA-R.S. 40:1299.44C.

5.

The Commissioner was sent a copy of the Petition on July 28, 1988. Plaintiff waited in excess of ten (10) days and on August 10, 1988, filed their Petition and served it on the Commissioner with a twenty (20) day citation as required by LSA-R.S. 40:1299.44C(3). The Commissioner was served on August 19, 1988.

6.

The Commissioner did not file any pleadings within the twenty (20) days, as required by LSA-R.S. 40:1299.44C(3) which in applicable part states:

> The Commissioner . . . may file written objections to the payment of the amount demanded. The agreement or objection to the payment shall be filed within twenty days after the petition is filed.

7.

The Plaintiff obtained a Court order on September 1, 1988, as required, to set the matter for hearing on Wednesday, September 14, 1988, all in conformity with the Statute, i.e. Paragraph Four (4), and local Court Rules for the First Judicial District Court.

8.

On September 12, 1988, the Commissioner filed "An Exception Of No Cause of Action" with an accompanying Memorandum in Support of Exception of No Cuase [sic] of Action and sent a letter to the Judge to whom this case is assigned, all of which Plaintiff filed in the records of these proceedings.

9.

The Commissioner's Attorney contacted Plaintiffs' counsel for the first time on Tuesday, September 13, 1988, after the pleadings were filed on September 12, 1988, advising that he would not attend the hearing scheduled

for the next day. It was understood and agreed that the hearing would proceed as ordered by the Court and duly set. The hearing was conducted on Wednesday, September 14, 1988, and the Court approved the Joint Petition for the Plaintiffs and Defendants to settle and Dr. Ricky Jones and Michael O. Fleming and Ricky L. Jones (A Medical Corporation) and ST. PAUL INSURANCE COMPANY, their malpractice insuror, paid the policy limits of $100,000.00, all in conformity with Paragraph C(5) of the Act.

10.

On September 15, 1988, the Commissioner as the "Office of the Commissioner of Insurance of the State of Louisiana, the Office of the Attorney General of the State of Louisiana, and the Louisiana Patient's Compensation Fund," filed an Answer.

11.

That the Plaintiffs-Claimants show that Paragraphs 4 and 5 of the Answer should be striken from the record as having been filed too late and insofar as it purports to object to the Plaintiffs and Defendants' Joint Petition to settle their claim and limit the provisions of Paragraph C(5) of the Act, which provides in applicable part, "In approving a settlement or determining the amount, if any, to be paid from the Patient's Compensation Fund, the Court shall consider the liability of the Health Care Provider as admitted and established where the insuror has paid its policy limits of One Hundred Thousand Dollars . . . . "

12.

The Exception of No Cause of Action should be overruled. Plaintiffs-Claimants show that they have followed exactly the language of LSA-R.S. 40:1299.44C and the Exception of No Cause of action has no merit. Plaintiffs show their rights to sanctions should be preserved, depending on the outcome of the Court's ruling on the Exception of No Cause of Action filed by the Commissioner.

13.

The Plaintiffs show that the Defendant's request in Paragraph 9 for a Jury Trial should be stricken as the Louisiana Patient's Compensation Fund is a budgetary arm of the State and Jury Trials are not available in claims against the State of Louisiana.

14.

The answer the Commissioner in Paragraph 6, wherein the claim of entitlment [sic] to the provisions of LSA-R.S. 40:1299.42B of the Act is made is vague, in that it does not set forth in detail in what manner the provisions of this section are applicable, and the Commissioner should be ordered to amend and set forth the facts upon which he relies for application of this provision.

15.

Plaintiffs show that the Defendant Commissioner in Paragraph 4 and 5 of their answer are in actuality claiming that since the Plaintiff named four (4) health care

providers in their original suit and petition to invoke a medical Review Panel, that the Plaintiffs must receive $100,000.00 for each Health Care Provider before the provisions of Paragraph C(5) of the Act are applicable. The Plaintiffs deny this. Plaintiffs show that there is or was no evidence that two (2) of the Health Care Providers, i.e. Dr. Michael O. Fleming and Dr. Marion Cash were at fault in any manner. That the Plaintiffs accepted the policy limits of Dr. Ricky Jones' for his malpractice insuror, St. Paul Insurance Company, which was $100,000.00, a copy of which check and release are attached and made a part hereof as if copied in extenso.

16.

The Plaintiffs plead alternatively and only should the Court determine that more than one (1) Health Care Provider was also guilty of medical malpractice, i.e., either Dr. Michael O. Fleming or Dr. Marion Cash, then Plaintiff shows that if each Health Care Provider must put $100,000.00 before Paragraph C(5) of the Act is applicable then in that event the Louisiana Patient's Compensation Fund would be liable for an additional $400,000.00. plus interest on each $100,000.00 paid-in by the Health Care Provider, thereby making the "cap" in this case $2,000,000.00.

17.

That Plaintiffs-Claimants show that at all material times herein:

A. Dr. Michael O. Fleming was a qualified Health Care Provider;

B. Dr. Ricky L. Jones was a qualified Health Care Provider;

C. Michael O. Fleming and Ricky L. Jones (A Medical Corporation) was a duly incorporated medical corporation;

D. Dr. Marion Cash was a qualified Health Care Provider; and,

E. Dr. Marion Cash was an employee of the medical corporation known as "Michael O. Fleming and Ricky L. Jones (A Medical Corporation)."

WHEREFORE, PLAINTIFFS-CLAIMANTS PRAY:

1. That after due proceedings had herein, there be judgment in favor of the Plaintiffs-Claimants as originally prayed for;

2. That there be judgment in favor of the Plaintiffs-Claimants, WALLY EUGENE STUKA & LORNA MARIE LARRIEU STUKA, and against the Defendants, STATE OF LOUISIANA and HON. DOUG GREEN, COMMISSIONER OF INSURANCE, for the State of Louisiana, in his capacity as such, Manager and Representative of the Louisiana Patient's Compensation Fund, *in solido*, for such damages as are reasonable in the premises, and all bills, together with legal interest from the date of judicial demand until paid, and all costs of proceedings, including expert witness fees.

3. That the Exception of No Cause of Action filed by the Commissioner, Douglas D. "Doug" Green, be overruled.

4. That the pleading entitled "Answer" be stricken as not being timely filed.

5. That, alternatively, if the "Answer" is not stricken in its entirety, that Paragraphs 4, 5, 6 and 7 be stricken.

6. That, alternatively, if Paragraph 6 is not stricken, then Commissioner, Douglas D. "Doug" Green, be ordered to cure the vagueness of this Paragraph by alleging the facts upon which the Commissioner relies to obtain the benefits of La.R.S. 40:1299.42B.

/s/ Donald R. Miller
DONALD R. MILLER APLC
725 SLATTERY BUILDING
SHREVEPORT, LA 71101
(318) 222-9417

ATTORNEY FOR PETITIONERS.

WALLY EUGENE STUKA & LORNA MARIE

LARRIEU STUKA	§	NUMBER: 330,930
VERSUS	§	FIRST JUDICIAL
DR. MICHAEL FLEMING, ET AL	§	DISTRICT COURT
	§	CADDO PARISH,
	§	LOUISIANA

ASSIGNED TO: JUDGE HAMILTON

JUDGMENT ON MOTION TO STRIKE PURSUANT TO LSA-C.C.P. ARTICLE 964; AND OPPOSITION TO DEFENDANT DOUGLAS D. "DOUG" GREEN LOUISIANA COMMISSIONER OF INSURANCE'S EXCEPTION OF NO CAUSE OF ACTION & EXCEPTION OF VAGUENESS

(Filed Oct. 13, 1988)

THIS CAUSE having come on regularly for hearing on the MOTION TO STRIKE PURSUANT TO LSA-C.C.P., ARTICLE 964; AND OPPOSITION TO DEFENDANT DOUGLAS D. "DOUG" GREEN LOUISIANA COMMISSIONER OF INSURANCE'S EXCEPTION OF NO CAUSE OF ACTION & EXCEPTION OF VAGUENESS, the Plaintiffs' Counsel, DONALD R. MILLER, being present in Open Court and submitting argument on said Motion, and JERALD L. PERLMAN, the Counsel of the Defendant, LOUISIANA PATIENTS COMPENSATION FUND, also being present in Open Court and submitting argument, the law the evidence considered.

IT IS ORDERED, ADJUDGED AND DECREED that the Exception Of No Cause of Action filed by DOUGLAS D. "DOUG" GREEN, in his capacity as Commissioner of Insurance for the State of Louisiana and as the statutory

administrator of the Louisiana Patient's Compensation Fund, be and it is hereby overruled.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Paragraphs 4, 5 and 6 of the Answer filed by the Office of the Commissioner of Insurance of the State of Louisiana, the Office of the Attorney General of the State of Louisiana, and the Louisiana Patient's Compensation Fund, be and they are hereby strickened from the record as having been filed too late insofar as Paragraph 4 and 5 purport to object to the Plaintiffs and Defendants' Joint Petition to settle their claim and limit the provisions of Paragraph C(5) of the provisions of *LSA-R.S. 40:1299, et seq,* and insofar as Paragraph 6 is determined as being vague and does not set forth the facts upon which the Commissioner relies.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that the Defendant's request in Paragraph 9 for a Jury Trial be and it is hereby strickened from the record as the Answer filed requesting a Jury Trial is filed by the Office of the Commissioner of Insurance of the State of Louisiana, the Office of the Attorney General of the State of Louisiana, and the Louisiana Patient's Compensation Fund and Jury Trials are not available on behalf of the Office of the Commissioner of Insurance of the State of Louisiana, the Office of the Attorney General of the State of Louisiana, and the Louisiana Patient's Compensation Fund.

JUDGMENT RENDERED the 11th day of OCTOBER, 1988; JUUDGMENT [sic] READ, SIGNED AND FILED the 13 day of OCTOBER, 1988.

/s/ Gayle K. Hamilton
HON. GAYLE HAMILTON,
DISTRICT JUDGE.

JUDGMENT PREPARED 10/12/88 BY:

/s/ Donald R. Miller
DONALD R. MILLER APLC
725 SLATTERY BUILDING
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(318) 222-9417

ATTORNEY FOR PETITIONERS.

JUDGMENT APPROVED 10/13/88 BY:

/s/ Jerald L. Perlman
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ATTORNEY FOR HON. DOUGLAS D.
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NOTICE OF LODGING – WRIT GRANT

DATE: 10/20/88

DOCKET NO. 20600-CW

BRIEF DUE:- 2/20/89

Stuka, Wally Eugene et ux
VS
Fleming, Dr. Michael et al

Appealed from
Parish of Caddo
No. 330930

The record of the writ granted in the above entitled matter, in which you are listed as counsel of record for the Defendant/Applicant, was this day received and filed. Please use our docket number on all correspondence and filings.

The Uniform Rules – Courts of appeal shall govern practice and procedure in all appeals and writs to this court. A complete copy of the Uniform Rules can be found in Vol. 8, Louisiana Revised Statutes, at the conclusion of LSA-R.S. Title 13.

You will be notified at least 30 days in advance of the date of oral argument, or of the date the case will be submitted to the court in the event oral argument is not requested.

*All requests for the return of conformed copies of filings MUST be accompanied by a self-addressed, stamped envelope.

FOR THE COURT

/s/ Virginia C. Smith
Dy. Clerk of Court

Wally Eugene STUKA and Lorna Marie Larrieu Stuka

v.

FLEMING, Dr. Michael et al.

No. 20,600-CW.

Court of Appeal of Louisiana, Second Circuit.

Oct. 27, 1988.
Writ Granted Jan. 13, 1989.

Carruth, Cooper & Adams by Ambrose Ramsey III, Baton Rouge, and Walker, Tooke, Perlman & Lyons by Jerald L. Perlman, Donald Miller, Shreveport, for La. Patient's Compensation Fund, Doug Green, Com'r of Ins.

Mayer, Smith & Roberts by Caldwell Roberts, Shreveport, for Wally Eugene Stuka and Lorna Marie Larrieu Stuka, Dr. Michael Fleming, Dr. Ricky L. Jones, Dr. Marion N. Cash and St. Paul Fire & Marine Ins.

Before HALL, SEXTON and LINDSAY, JJ.

WRIT GRANTED AND MADE PEREMPTORY.

The applicant, the Louisiana Patient Compensation fund, seeks supervisory review of a trial court ruling striking certain paragraphs from its answer to the plaintiffs' petition to recover from the fund for injuries allegedly caused by medical malpractice.

The plaintiffs filed suit against several doctors claiming they were negligent in their care of Mrs. Stuka. The plaintiffs also sued a medical corporation, as well as a

medical malpractice insurer. One of the doctors, the medical corporation and the medical malpractice insurer settled with the plaintiffs for one hundred thousand dollars. The terms of the settlement did not admit liability on the part of the health care providers.

The plaintiffs also filed suit against the Louisiana Patient Compensation Fund for damages over and above the amount received in settlement from the health care providers and their insurer.

The Louisiana Patient Compensation Fund answered, requesting a jury trial and alleging that the health care providers were not negligent in their care of Mrs. Stuka and that the Fund was entitled to litigate this issue at trial. The plaintiffs filed a motion to strike those provisions from the Fund's answer. The motion was granted by the trial court.

The trial court erred in granting the plaintiffs' motion to strike.

The Louisiana Supreme Court in *Williams v. Kushner*, 449 So.2d 455 (La. 1984) found that there is no prohibition against a jury trial under the Medical Malpractice Act. The Court found LSA-R.S. 13:5105 inapplicable. As a party to this suit, within the meaning of LSA-C.C.P. Art. 1733, the Louisiana Patient Compensation Fund has the right to request a jury trial.

Under LSA-R.S. 40:1299.41, the definition of health care providers includes persons and corporations licensed by the state to provide health care. The record before us establishes that the plaintiffs reached a partial settlement with two health care providers, Dr. Ricky L.

Jones, as well as Michael O. Fleming and Ricky L. Jones (A Medical Corporation) and their insurance carrier. Plaintiffs dismissed their claims against other original defendant – health care providers, with prejudice, "in further consideration of the foregoing payment" of one hundred thousand dollars. The settlement provided that the plaintiffs were to receive a total of one hundred thousand dollars, rather than the liability limit of one hundred thousand dollars per health care provider established under LSA-R.S. 40:1299.42(B)(2). Therefore, plaintiffs have apparently entered into a partial settlement, have not obtained the maximum amount from each health care provider, have dismissed their claims against other health care providers, and now seek to obtain additional amounts from the Fund, claiming that LSA-R.S. 40:1299.44(C)(5) relieves them from the necessity of proving that the fault of the health care providers caused the injuries of which they complain.

LSA-R.S. 40:1299.44(C)(5) provides that the court shall consider the liability of the health care provider as admitted and established where the insurer has paid its policy limits of one hundred thousand dollars. In the present case, the policy limits of one hundred thousand dollars have not been paid on behalf of each health care provider. This amount was paid on behalf of two health care providers, without apportionment. Therefore, under the statute, their fault and liability is not deemed admitted as it affects the right of the Fund to deny liability and litigate that issue. Because the issue of liability has not been previously adjudicated or admitted by the Fund, the issue is properly before the trial court and may be asserted by the Louisiana Patient Compensation Fund.

Therefore, the applicant's writ is granted and the trial court judgment granting the plaintiffs' motion to strike is vacated. The case is remanded to the trial court for further proceedings in accordance with law.

Wally Eugene STUKA and Lorna Marie Larrieu Stuka

v.

Dr. Michael FLEMING, et al.

No. 88-CC-2707.

Supreme Court of Louisiana.
Jan. 13, 1989.

In re Stuka, Wally Eugene; Stuka, Lorna Marie Larrieu; – Plaintiff(s); applying for supervisory and/or remedial writs; to the Court of Appeal, Second Circuit, No. 20600-CW; Parish of Caddo, 1st Judicial District Court, Div. "G", No. 330930.

Prior report: La.App. 532 So.2d 1204.

Granted, Case remanded to the Court of Appeal for briefing, argument and an opinion.

LEMMON, J., votes to grant the application and docket the case for argument, particularly to consider whether the settlement with one doctor (while releasing the other two doctors) and with the medical corporation (which appears to be only vicariously liable) is a settlement with one health care provider which constitutes the admission of the liability of that health care provider.

Wally Eugene STUKA and Lorna Marie Larrieu Stuka, Plaintiffs,

v.

Dr. Michael FLEMING, et al., Defendants.

No. 20600-CW.

Court of Appeal of Louisiana, Second Circuit.

May 10, 1989.

Patient brought action against patient compensation fund for damages over and above $100,000 received in medical malpractice settlement from health care providers and their insurer. The First Judicial District Court, Caddo Parish, Gayle K. Hamilton, J., granted patient's motion to strike, which had effect of denying fund right to jury trial and right to litigate issue of liability of health care providers. Fund sought supervisory writ. The Court of Appeal, 532 So.2d 1204, granted writ. Upon application to the Louisiana Supreme Court, 536 So.2d 1206, Court of Appeal's opinion was set aside and case was remanded. On remand, the Court of Appeal, Lindsay, J., held that: (1) patient compensation fund had right to request jury trial, and (2) settlement of claims against three health care providers for only single $100,000 payment did not trigger admission of liability provision, and thus the issue of liability could be litigated by fund in determining amount of excess damages to be paid by fund.

Reversed and remanded for further proceedings.

Walter, Tooke, Perlman, Lyons & Clawson by Jerald L. Perlman, Shreveport, for defendants.

Donald R. Miller, APLC, Shreveport, for plaintiffs.

Before HALL, SEXTON and LINDSAY, JJ.

LINDSAY, Judge.

This case is before this court on remand from the Louisiana Supreme Court. The Louisiana Patient Compensation Fund (the Fund) originally applied to this court for supervisory writs seeking review of a trial court decision denying the Fund the right to trial by jury and the right to litigate the issue of liability of certain health care providers. This court ruled in favor of the Fund, granted the writ and made it peremptory, recognizing the Fund's right to jury trial and the right to litigate the liability of the health care providers. Upon a writ application to the Louisiana Supreme Court, this court's opinion, 532 So.2d 1204 (La.App.2d Cir.1988), was set aside and the case was remanded for briefing, argument and opinion. *Stuka v. Fleming*, 536 So.2d 1206 (La.1989). Having again reviewed the record, the briefs and argument of counsel, for the following reasons, we adhere to our original opinion and reverse the trial court judgment.

FACTS

This is a medical malpractice case.[1] The plaintiffs are Wally Eugene Stuka and Lorna Marie Larrieu Stuka. The defendants include the following qualified health care providers, Dr. Michael O. Fleming, Dr. Ricky L. Jones, Dr. Marion Cash and the medical corporation employing the

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[1] The facts set forth in this opinion are drawn from the pleadings, as there has not been a trial on the merits.

three doctors, Michael O. Fleming and Ricky L. Jones (a Medical Corporation).

Lorna Stuka was diagnosed as pregnant in mid-August, 1985. On November 6, 1985 she consulted Dr. Fleming with sinus problems. She continued to have severe headaches and nausea during the course of her pregnancy. These headaches were treated with Tylenol, Keflex and Demerol. From November, 1985, to March, 1986 the plaintiff consulted with Dr. Fleming, or one of his partners, Dr. Jones or Dr. Cash, on numerous occasions regarding her headaches.

On March 13, 1986, the plaintiff saw Dr. Jones with severe nausea, vomiting and headaches. By March 18, 1986, the plaintiff was constantly throwing up and was given Demerol by Dr. Jones.

Mrs. Stuka's condition continued to deteriorate until March 21, 1986 when she was admitted to the hospital. At that time, she was found to have a brain abscess in the right frontal lobe, caused by a sinus infection. The plaintiff underwent a right front temporal craniotomy which left her subject to seizures and some brain damage. Her baby was delivered by emergency cesarean section on March 30, 1986.

The plaintiffs claimed medical malpractice in failing to properly treat Mrs. Stuka's sinus infection and avoiding the brain abscess. A medical review panel was formed to consider the claim.

The plaintiffs filed suit on February 20, 1987. Originally, the plaintiffs filed suit against only Drs. Fleming, Jones and Cash. At some point after the suit was filed the

parties apparently entered into settlement negotiations and arrived at an agreement. On August 10, 1988, pursuant to the procedures set forth in the Medical Malpractice Act, the plaintiffs filed an amended petition, seeking judicial approval of their settlement agreement. In this amended petition seeking settlement approval, in addition to the three doctors originally named as defendants, the plaintiffs also added as defendants the medical corporation employing the three doctors, their medical malpractice insurer, St. Paul Fire and Marine Insurance Company, the State of Louisiana and the Louisiana Patient Compensation Fund through the Commissioner of Insurance. Under the terms of the settlement, in consideration of a payment of $100,000 on behalf of Dr. Jones and the medical corporation by the malpractice insurer, the plaintiffs dismissed with prejudice any claims they might have against Dr. Fleming and Dr. Cash. The plaintiffs agreed to accept the $100,000 settlement and assert their claim for $400,000 in additional medical damages against the Louisiana Patient Compensation Fund.

On August 19, 1988, the Commissioner and the Fund were served with the petition in which the settlement agreement was set forth, including the claim against the Fund for additional damages of $400,000. The Fund took no action at that time. On September 14, 1988, judgment was entered by the trial court approving the settlement.

On September 15, 1988, the Commissioner and the Fund filed an answer contending that the settlement agreement was not an admission of liability on the part of the health care providers. Therefore, the Fund contended that at trial it should be able to assert that the doctors

were not negligent in their care of Mrs. Stuka. The Fund also requested a jury trial.

On October 3, 1988, the plaintiffs filed a motion to strike paragraphs 4, 5, 6 and 9 of the Fund's answer. Those paragraphs are as follows:

4.

It is submitted that the settlement described above wherein four health care providers are released in consideration of a payment of $100,000.00 does not constitute an admission of liability under the provisions of La.R.S. 40:1299.44C(5). Consequently, all issues, including the issues of whether there was a breach of the standard of care, how many, if any, of the health care providers breached the standard of care, and the amount of the damages owed as a result of any proven breach of the standard of care are still at issue and must all be litigated to conclusion.

5.

Respondents have denied and continue to deny that any of the health care providers breached the appropriate standard of care in their treatment of petitioner, Lorna Marie Larrieu Stuka.

6.

In the alternative, and only in the event that this court determines that any of the health care providers did in fact breach the appropriate standard of care, the office

of the Commissioner of Insurance, the office of the Attorney General of the State of Louisiana, and the Louisiana Patient's Compensation Fund claim and are entitled to the provisions of the Louisiana Medical Malpractice Act, La.R.S. 40:1299.41, et seq, particularly La.R.S. 40:1299.42B.

9.

Respondents pray for trial by jury on all issues.

The plaintiffs argued that, as to paragraphs 4 and 5, the Fund failed to raise an objection to the settlement within the twenty day time limit required by LSA-R.S. 40:1299.44 C(3) and were therefore precluded from doing so in its answer. The plaintiffs argued that according to the settlement, it was determined that only Dr. Jones was liable for Mrs. Stuka's damage and that, because the policy limits of $100,000 had been paid by the medical malpractice insurer, Dr. Jones' liability was admitted and therefore liability was no longer at issue.

The plaintiffs argued that paragraph 6 was vague. They also contended that the Fund was not entitled to a jury trial as prayed for in paragraph 9.

On October 13, 1988, the trial court entered judgment striking paragraphs 4 and 5, finding the claims alleged therein were asserted too late. Paragraph 6 was also stricken, the court finding that the paragraph was vague and did not set forth any facts.

Paragraph 9 was stricken, the trial court holding that the Fund was not entitled to a jury trial.

The defendants filed an application for supervisory writs in this court. On October 27, 1988, we granted the

writ application, made it peremptory and remanded the case to the trial court for further proceedings. We stated that under *Williams on Behalf of Williams v. Kushner*, 449 So.2d 455 (La.1984), the Fund was entitled to a jury trial. That case held that LSA-R.S. 13:5105, which precludes jury trials in suits against the state and its subdivisions, is not applicable to cases involving the Fund.

We also found that the plaintiffs had settled only with Dr. Jones, the corporation and their insurance carrier, obtaining nothing from the other health care providers named in the suit. We held that because there was not a settlement for the total policy limits of all health care providers, but only a partial settlement, the issue of liability was still open for litigation at trial and that the Fund could therefore assert the lack of negligence of the health care providers.

The plaintiffs then applied for writs to the Louisiana Supreme Court. On January 13, 1989, that court granted the plaintiffs' writ application and remanded the case to this court for "briefing, argument and an opinion."

The parties have briefed the case to this court on the issues of whether the Fund is entitled to a trial by jury and whether liability is an issue which may be litigated by the Fund.

RIGHT TO JURY TRIAL

In the trial court, the plaintiffs originally requested a trial by jury, but withdrew that request when the proposed settlement agreement was presented to the trial judge for consideration. In their answer, filed the day

after the settlement was approved, the Fund requested a jury trial on the issues relating to the plaintiffs' claim for excess damages from the Fund.

The plaintiffs argued in the trial court that the Fund was not entitled to request a trial by jury. The trial court agreed and ordered stricken that portion of the Fund's answer which requested a jury trial. We find that the trial court erred in denying the Fund's request for a jury trial. Accordingly, we reverse that portion of the trial court judgment.

LSA-C.C.P. Art. 1733 provides in pertinent part:

> A. A party may obtain a trial by jury by filing a pleading demanding a trial by jury and a bond in the amount and within the time set by the court pursuant to Article 1734.

In *Williams on Behalf of Williams v. Kushner,* 449 So.2d 455 (La.1984), a claimant who had settled with a health care provider for his $100,000 limit of liability sought to obtain $400,000 in excess damages from the Fund. The claimant requested a jury trial for a determination of the excess amount of damages recoverable from the Fund. In that case, the Fund argued the claimant was not entitled to a jury trial because the Fund is a budgetary unit of the state and jury trials against the state are statutorily prohibited.

The court found the Medical Malpractice Act did not deny a medical malpractice claimant, who had settled with a qualified health care provider or his insurer, the right to trial by jury on the amount of damages recoverable from the Fund. Because a suit under the Medical Malpractice Act is against the health care provider and

not against the Fund, an alleged state agency, the prohibition against jury trials involving the state, under LSA-R.S. 13:5105, is not applicable.

The plaintiffs in this case argue that although *Williams on Behalf of Williams v. Kushner, supra,* grants them the right to request a jury trial in a proceeding to recover from the Fund, the case is not authority for allowing the Fund to request a jury trial. The plaintiffs claim that the Fund is only an intervener and, as such, does not possess the right to request a trial by jury.

Williams on Behalf of Williams v. Kushner, supra, supports the view that the Fund is an intervener. In *Felix v. St. Paul Fire & Marine Insurance Company,* 477 So.2d 676 (La.1985), the court also held that in a malpractice case, the Fund is not a defendant, but is a statutory intervener with a statutory interest in defending the Fund against claimants seeking excess damages. Under the statutory scheme of the Medical Malpractice Act, the Fund is not named as a defendant in a proceeding to obtain excess damages above the $100,000 liability limit payable by health care providers and their insurers.

In *Felix,* the court held the Fund is a third person with an interest in the proceedings between the claimant and the health care provider, because any damages in excess of $100,000 per health care provider, will be paid by the Fund.

The plaintiffs assert that LSA-C.C.P. Art. 1094 bars an intervener from seeking a jury trial. That article provides:

> An intervener cannot object to the form of the action, to the venue, or to any defects and informalities personal to the original parties.

We find that under the particular facts presented in this case, LSA-C.C.P. Art. 1094 does not bar the Fund from seeking a jury trial. Long ago the Supreme Court of this state recognized the right of an intervener to seek a jury trial. In *LaCroix v. Menard,* 3 Martin N.S. 339 (La.1825), the court found that although an intervener is neither a plaintiff or a defendant, he either opposes the claims of one or both of the parties litigating and in that light is an actor in the cause.

The court went on to state that:

> By whatever appellation he be designated, it appears to us a necessary consequence of admitting him as a party, that he should have the same right in proving his case, and trying it, and in enforcing his judgment, as those who were originally plaintiffs and defendants.

This case was decided long before the enactment of LSA-C.C.P. Art. 1094 which now arguably operates to preclude a regular intervener from seeking a jury trial in any proceeding in which he interjects himself.

However, in this case, the Fund, as a statutory intervener, is in a posture different from that of a general, voluntary intervener. A voluntary intervener, rather then proceeding by intervention, may choose to bring a separate suit to enforce any claim he may have, or assert his rights when a separate suit is brought against him. In medical malpractice cases, the Fund is drawn in as an intervener by the plaintiffs, rather than choosing to interject itself into the suit, in order to defend against claims for excess damages.

Under the act, it is necessary that the Fund be served with a judgment or settlement in favor of a plaintiff in

order for the plaintiff to then assert a claim for excess damages (up to $400,000) from the Fund.

It is at that point, on the action of the plaintiff, that the Fund becomes a statutory intervener and has a significant interest in defending against claims for excess damages. It is only at this stage of the proceedings that the Fund, as a statutory intervener, is required to defend against claims for excess damages. Therefore, it seems imperative that if a claimant is to be afforded the right to a jury trial in seeking excess damages from the Fund, then fundamental fairness requires that the Fund, forced into the litigation to respond for excess damages, should also be afforded the right to request a trial by jury in defending against such claims.

We also note that although *Williams on Behalf of Williams v. Kushner, supra,* held that only the health care provider is a defendant in a medical malpractice suit, in the present case, the insurance commissioner and the Fund were specifically named as defendants in the plaintiffs' pleadings.

The plaintiffs also contend that the Fund's request for a jury trial was not timely filed. However, we find that the Fund's request was timely under LSA-C.C.P. Art. 1733(C) which provides:

> C. The pleading demanding a trial by jury shall be filed not later than ten days after either the service of the pleadings directed to any issue triable by a jury, or the granting of a motion to withdraw a demand for a trial by jury.

The plaintiffs withdrew their request for a jury trial on September 14, 1988. On the next day, September 15,

1988, at the earliest possible time under the circumstances, the Fund filed an answer, including a request for a jury trial. The Fund's request was timely.

Accordingly, the Fund's request for jury trial shall be maintained.

LIABILITY

When the plaintiffs initially filed their suit for medical malpractice, they alleged malpractice on the part of three health care providers. Plaintiffs claimed that, Dr. Michael Fleming, Dr. Marion Cash and Dr. Ricky Jones, all of whom practiced together, examined and treated Mrs. Stuka during the time of her sinus infection and resulting brain abscess, and that they each failed to properly diagnosis and treat her condition.

The plaintiffs later filed a supplemental and amending petition, seeking approval of a settlement with the health care providers. In that petition, the plaintiffs added another health care provider. In addition to the doctors originally named, the plaintiffs added the medical corporation which employed the three original defendants. Plaintiffs also added St. Paul Fire & Marine Insurance Company, the medical malpractice insurer of the four health care providers, as well as the State of Louisiana and the Commissioner of Insurance.

In the amended petition, the plaintiffs alleged that the substandard care of Dr. Jones resulted in Mrs. Stuka's brain abscess. Under the terms of the settlement, St. Paul Fire and Marine Insurance Company paid the plaintiffs

$100,000 on behalf of Dr. Jones and the medical corporation. In exchange, the plaintiffs dismissed with prejudice their claims against the other health care providers, Drs. Fleming and Cash, "in further consideration of the foregoing payment" of $100,000. The plaintiffs also released the medical corporation and Dr. Jones from "individual" liability.

Under the Medical Malpractice Act, when the $100,000 liability limitation is paid on behalf of a health care provider, liability of that health care provider is admitted. The plaintiffs argue that because $100,000 has been paid on behalf of the health care providers by the insurer, liability is admitted and the Fund is precluded from litigating that issue at trial. The Fund argues that the $100,000 liability limit per health care provider has not been paid and therefore liability has not been admitted as to any of the health care providers named in the suit.

LSA-R.S. 40:1299.42 B(1) provides that the total amount recoverable for any death or injury to a patient may not exceed $500,000.

LSA-R.S. 40:1299.42 B (2) and (3) provide that a health care provider is not liable in excess of $100,000 for all claims of malpractice resulting in injury or death to any one person, and that any excess amounts up to $500,000 are to be paid by the Fund.

LSA-R.S. 40:1299.44 C(5), dealing with settlement of malpractice claims, provides that, in approving settlements and determining what amount, if any, is to be paid by the Fund, in those cases where the insurer has paid the

policy limit of $100,000, the court shall consider the liability of the health care provider admitted and established.

However, LSA-R.S. 40:1299.42 D(5) provides that in the event that a partial settlement is executed between plaintiffs and the defendant and/or his insurer for the sum of $100,000 or less, written notice of such settlement shall be sent to the attorney general. Such settlement shall not bar the continuation of the action against the Patient's Compensation Fund for excess sums. In such situations, where the policy limits have not been paid by the insurer on behalf of each named health care provider, the issue of liability has not been admitted and may be litigated. *Simon v. Smith*, 470 So.2d 941 (La.App. 3rd Cir.1985), writ denied 476 So.2d 353, 355 (La.1985); *Kelty v. Brumfield*, 534 So.2d 1331 (La.App. 4th Cir.1988).

In the present case, the plaintiffs argue that the $100,000 policy limit was paid on behalf of Dr. Jones alone. Therefore, they argue, his liability is admitted and cannot be litigated by the Fund in the consideration of the issue of excess damages.

Under the facts of this case, St. Paul Fire & Marine Insurance provided insurance coverage in the amount of $100,000 for each of the original defendant health care providers. It appears from the settlement agreement that the insurer of the defendant health care providers made a single, $100,000 payment for the release of all three doctors, i.e., Drs. Fleming, Cash and Jones, as well as the medical corporation, rather than paying the policy limits for each defendant. Therefore, liability on the part of no defendant is admitted.

The pleadings before us reveal that in the settlement agreement, the three doctors, the corporation, and the insurer settled the claim against all for $100,000.[2] The effort to structure the settlement so as to make it appear to be a settlement only as to Dr. Jones for the full $100,000 policy limits applicable to him, thus triggering the statute's admission of liability provision, does not change the reality of the situation.

It is clear from the statute that a settlement with one health care provider for less than the $100,000 policy limits does not trigger the admission of liability which would be binding on the Fund. It follows that a settlement of claims against three health care providers for only a single, $100,000 payment likewise does not trigger the admission of liability provision.

Under the facts of this case, the insurer of the health care providers has not paid the policy limits of $100,000 for any one health care provider as required to constitute an admission of liability under the Medical Malpractice Act. The $100,000 payment has been made to settle the claim against three health care providers, and possibly a fourth, the Medical Corporation. Therefore, the issue of liability may be litigated by the Fund in determining the amount of excess damages to be paid by the Fund.

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[2] The present case is distinguishable from *Kelty v. Brumfield, supra.* In *Kelty,* one health care provider settled for the $100,000 liability limit, thus admitting liability for the injury, although another health care provider settled for less than $100,000. In the present case, four health care providers settled a potential $400,000 claim for $100,000. Therefore, the liability limit was not paid on behalf of any one health care provider and the issue of liability is not admitted.

In addition, the plaintiffs claim that the Fund had only twenty days from the filing of the settlement petition to file its answer or objection to the settlement. They claim that the Fund's answer, filed September 15, 1988, after the settlement was approved by the court, was not timely, and, therefore, the Fund cannot contest liability. This argument is meritless. We find that the Fund acted timely in filing its answer and in seeking to defend against the plaintiffs' claims for excess damages.

The plaintiffs claim that they proceeded under the settlement provisions of LSA-R.S. 40:1299.44 C. A petition for approval of the settlement was filed in the trial court and a copy of the petition was timely served on the Insurance Commissioner who represents the Fund. However, the settlement in this case did not include an agreement between the plaintiffs and the Fund as to the amount of excess damages to be paid by the Fund.

LSA-R.S. 40:1299.44 C(5) provides that where there is no agreement as to the amount to be paid by the Fund, the court shall determine the amount of the claimant's damages, if any, in excess of the amount already paid by the insurer of the health care provider. This determination of the amount to be paid by the Fund comes following a trial, and not as a part of the settlement process between the plaintiff and the health care providers and their insurer.

In this case, because the Fund was not a party to the settlement, the Fund had no duty to act. The Fund had no duty to act until the issue of excess damages was properly before the court, following the approval of the partial

settlement between the plaintiff and the defendant health care providers.

Under the facts presented herein, the Fund acted timely and properly in filing its answer.

CONCLUSION

For the above stated reasons, we reaffirm our original decision and opinion. Accordingly, we reverse the trial court judgment denying the Louisiana Patient Compensation Fund the right to a jury trial on the issue of excess damages to be paid by the Fund. We also reverse the trial court judgment denying the Fund the right to litigate the issue of liability of the health care providers.

REVERSED AND REMANDED FOR FURTHER PROCEEDINGS, at plaintiffs' costs.

Wally Eugene STUKA and Lorna Marie Larrieu Stuka

v.

Dr. Michael FLEMING, et al.

No. 89-CC-1391.

Supreme Court of Louisiana.

Sept. 22, 1989.

In re Stuka, Wally Eugene; Stuka, Lorna Marie Larrieu; – Plaintiff(s); applying for writ of certiorari and/or review, supervisory and/or remedial writs; to the Court of Appeal, Second Circuit, No. 20600-CW; Parish of Caddo, 1st Judicial District Court, Div. "G," No. 330930.

Prior report: La.App., 543 So.2d 1374.

Granted.

PART XXIII. MEDICAL MALPRACTICE

This Part, enacted by Acts 1975, No. 817 as Park XX, has been redesignated on authority of R.S. 24:253.

§ 1299.41. Definitions and general applications

A. As used in this Part:

(1) "Health care provider" means a person, partnership, corporation, facility, or institution licensed by this state to provide health care or professional services as a physician, hospital, community blood center, tissue bank, dentist, registered or licensed practical nurse, ambulance service under circumstances in which the provisions of R.S. 40:1299.39 are not applicable, certified registered nurse anesthetist, nurse midwife, pharmacist, optometrist, podiatrist; chiropractor, physical therapist, or psychologist, or any professional corporation a health care provider is authorized to form under the provisions of Title 12 of the Louisiana Revised Statutes of 1950, or an officer, employee, or agent thereof acting in the course and scope of his employment.

(2) "Physician" means a person with an unlimited license to practice medicine in this state.

(3) "Patient" means a natural person who receives or should have received health care from a licensed health care provider, under a contract, express or implied.

(4) "Hospital" means any hospital as defined in R.S. 40:2102; any "nursing home" or "home" as defined in R.S. 40:2009.2; or any physician's or dentist's offices or clinics containing facilities for the examination, diagnosis, treatment or care of human illnesses.

(5) "Commissioner" means the commissioner of insurance of this state.

(6) "Representative" means the spouse, parent, guardian, trustee, attorney or other legal agent of the patient.

(7) "Tort" means any breach of duty or any negligent act or omission proximately causing injury or damage to another. The standard of care required of every health care provider, except a hospital, in rendering professional services or health care to a patient, shall be to exercise that degree of skill ordinarily employed, under similar circumstances, by the members of his profession in good standing in the same community or locality, and to use reasonable care and diligence, along with his best judgment, in the application of his skill.

(8) "Malpractice" means any unintentional tort or any breach of contract based on health care or professional services rendered, or which should have been rendered, by a health care provider, to a patient, including failure to render services timely and the handling of a patient, including loading and unloading of a patient, and also includes all legal responsibility of a health care provider arising from defects in blood, tissue, transplants, drugs and medicines, or from defects in or failures of prosthetic devices, implanted in or used on or in the person of a patient.

(9) "Health care" means any act, or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical care, treatment or confinement.

(10) "Risk manager" means an insurance company with no less than an "A" rating according to the then current annual edition of Best's Insurance Reports or a domestic insurance company with assets in excess of ten million dollars chosen by the commissioner according to the public bid laws of the state, to manage the authority.

(11) "Risk" means any health care provider which shall apply for malpractice liability insurance coverage under the provisions of Section 1299.46.

(12) "Insurer" means the authority or the entity chosen to manage the authority or an insurer writing policies of malpractice insurance.

(13) "Authority" means the Residual Malpractice Insurance Authority established under Section 1299.46.

(14) "Proof of financial responsibility" as provided for in this Part shall be determined by the commissioner of insurance in accordance with regulations enacted under the Administrative Procedures Act of Louisiana.

(15) "Court" means a court of competent jurisdiction and proper venue over the parties.

(16) "Ambulance service" means an entity under circumstances in which the provisions of R.S. 40:1299.39 are not applicable which operates either ground or air ambulances, using a minimum of two persons on each ground ambulance, at least one of whom is trained and registered at the level of certified emergency medical technician-basic, or at the intermediate or paramedic levels, or one who is a registered nurse, and using a minimum on any air ambulance of one person trained

and registered at the paramedic level or a person who is a registered nurse, or any officer, employee, or agent thereof acting in the course and scope of his employment.

(17) "Community blood center" means any independent nonprofit nonhospital based facility which collects blood and blood products from donors primarily to supply blood and blood components to other health care facilities.

(18) "Tissue bank" means any independent nonprofit facility procuring and processing human organs or tissues for transplantation, medical education, research, or therapy.

B. Wherever necessary to the context of this Part the masculine shall mean and include the feminine and the singular shall mean and include the plural.

C. No liability shall be imposed upon any health care provider on the basis of an alleged breach of contract, whether by express or implied warranty, assuring results to be obtained from any procedure undertaken in the course of health care, unless such contract is expressly set forth in writing and signed by such health care provider or by an authorized agent of such health care provider.

D. A health care provider who fails to qualify under this Part is not covered by the provisions of this Part and is subject to liability under the law without regard to the provisions of this Part. If a health care provider does not so qualify, the patient's remedy will not be affected by the

terms and provisions of this Part, except as hereinafter provided with respect to the suspension and the running of prescription of actions against a health care provider who has not qualified under this Part when a claim has been filed against the health care provider for review under this Part.

E. (1) Subject to R.S. 40:1299.47, a person having a claim under this Part of bodily injuries to or death of a patient on account of malpractice may file a complaint in any court of law having requisite jurisdiction.

(2) No dollar amount or figure shall be included in the demand in any malpractice complaint, but the prayer shall be for such damages as are reasonable in the premises.

(3) This Section shall not prevent a person from alleging a requisite jurisdictional amount in a malpractice claim filed in a court requiring such an allegation.

F. The provisions of this Part do not apply to any act of malpractice which occurred before September 1, 1975. The provisions of this Part that provide for the suspension and the running of prescription with respect to a health care provider who has not qualified under this Part, but against whom a claim has been filed under this Part, do not apply to any act of malpractice which occurred before September 1, 1981.

G. Notwithstanding the provisions of Subsection D, the running of prescription against a health care provider who is answerable in solido with a qualified health care

provider against whom a claim has been filed for review under this Part shall be suspended for a period of ninety days after a panel is formed under the provisions of this Part, provided a claim is made against the in solido obligor either under the provisions of this Part or in a court of law within the ninety day period. For the purpose of this Part the panel shall be deemed to be formed on the date that the third health care provider member of the panel is chosen.

H. The provisions of this Part do not apply to any act of malpractice which occurred before September 1, 1975. The provisions of this Part that provide for the suspension of the running of prescription with respect to a health care provider who is answerable in solido with another health care provider apply to an act of malpractice which has been duly submitted for review prior to September 1, 1981 but in which the third health care provider panelist has not been selected. The provision for the suspension of the running of prescription does not apply to any act of malpractice which has not been duly submitted for review and which has prescribed on September 1, 1981.

I. Nothing in this Part shall be construed to make the patient's compensation fund liable for any sums except for those arising from medical malpractice. Notwithstanding any other law to the contrary, including but not limited to R.S. 13:5106, the provisions of this Part shall not apply to medical malpractice actions against the state or any political subdivision thereof with the exception of a hospital service district and a municipally

owned hospital and any entities, organizations, or subsidiary owned, operated, or controlled by such a hospital service district or municipally owned hospital.

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§ 1299.42. Limitation of recovery

A. To be qualified under the provisions of this Part, a health care provider shall:

(1) Cause to be filed with the commissioner proof of financial responsibility as provided by Subsection E of this Section;

(2) Pay the surcharge assessed by this Part on all health care providers according to R.S. 40:1299.44; and

(3) For self-insureds, qualification shall be effective upon acceptance of proof of financial responsibility by and payment of the surcharge to the commissioner of insurance. Qualification shall be effective for all others at the time the malpractice insurer accepts payment of the surcharge.

B. (1) The total amount recoverable for all malpractice claims for injuries to or death of a patient, exclusive of future medical care and related benefits as provided in R.S. 40:1299.43, shall not exceed five hundred thousand dollars plus interest and cost.

(2) A health care provider qualified under this Part is not liable for an amount in excess of one hundred thousand dollars for all malpractice claims because of injuries to or death of any one patient.

(3)(a) Any amount due from a judgment or settlement or from a final award in an arbitration proceeding which is in excess of the total liability of all liable health care providers, as provided in Paragraph (2) of this Subsection, shall be paid from the patient's compensation fund pursuant to the provisions of R.S. 40:1299.44(C).

(b) The total amounts paid in accordance with Paragraphs (2) and (3) of this Subsection shall not exceed the limitation as provided in Paragraph (1) of this Subsection.

C. Except as provided in R.S. 40:1299.44(C), any advance payment made by the defendant health care provider or his insurer to or for the plaintiff, or any other person, may not be construed as an admission of liability for injuries or damages suffered by the plaintiff or anyone else in an action brought for medical malpractice.

D. (1) Evidence of an advance payment is not admissible until there is a final judgment in favor of the plaintiff, in which event the court shall reduce the judgment to the plaintiff to the extent of the advance payment.

(2) The advance payment shall inure to the exclusive benefit of the defendant or his insurer making the payment.

(3) In the event the advance payment exceeds the liability of the defendant or the insurer making it, the court shall order any adjustment necessary to equalize the amount which each defendant is obligated to pay, exclusive of costs.

(4) In no case shall an advance payment in excess of an award be repayable by the person receiving it.

(5) In the event that a partial settlement is executed between the defendant and/or his insurer with a plaintiff for the sum of one hundred thousand dollars or less, written notice of such settlement shall be sent to the attorney general. Such settlement shall not bar the continuation of the action against the patient's compensation fund for excess sums, in which event the court shall reduce any judgment to the plaintiff in the amount of malpractice liability insurance in force as provided for in R.S. 40:1299.42(B)(2).[1] If such a partial settlement is made, either party shall be entitled to a continuance, which shall be not less than sixty days.

E. Financial responsibility of a health care provider under this Section may be established only by filing with the commissioner proof that the health care provider is insured by a policy of malpractice liability insurance in the amount of at least one hundred thousand dollars per claim with qualification under this Section taking effect and covering the same period and following the same form as the policy of malpractice liability insurance of the health care provider or, in the event the health care provider is self-insured, proof of financial responsibility in excess of one hundred thousand dollars.

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[1] In subsec. D, "in the amount of malpractice liability insurance in force as provided for in R.S. 40:1299.42(B)(2)" reads as it appears in the enrolled act.

§ 1299.43. Future medical care and related benefits

A (1) In all malpractice claims filed with the commissioner, of insurance which proceed to trial, the jury shall be given a special interrogatory asking if the patient is in need of future medical care and related benefits and the amount thereof.

(2) In actions upon malpractice claims tried by the court, the court's finding shall include a recitation that the patient is or is not in need of future medical care and related benefits and the amount thereof.

(3) If the total amount is for the maximum amount recoverable, exclusive of the value of future medical care and related benefits, the cost of all future medical care and related benefits shall be paid in accordance with this Section.

(4) If the total amount is for the maximum amount recoverable, including the value of the future medical care and related benefits, the amount of future medical care and related benefits shall be deducted from the total amount and shall be paid from the patient's compensation fund as incurred and presented for payment. The remaining portion of the judgment shall be paid in accordance with R.S. 40:1299.44(A)(7) and 40:1299.44(B)(1), (B)(2) and (B)(3).

(5) In all cases where judgment is rendered for a total amount less than the maximum amount recoverable, including any amount awarded on future medical care and related benefits, payment shall be in accordance with R.S. 40:1299.44(A)(7) and 40:1299.44(B)(1), (B)(2), and (B)(3).

(6) The provisions of this Subsection shall be applicable to all malpractice claims filed on or after September 1, 1984.

B. (1) "Future medical care and related benefits" for the purpose of this Section means all reasonable medical, surgical, hospitalization, physical rehabilitation, and custodial services and includes drugs, prosthetic devices, and other similar materials reasonably necessary in the provision of such services.

(2) "Future medical care and benefits" as used in this Section shall not be construed to mean non-essential specialty items or devices of convenience.

C. Once a judgment is entered in favor of a patient who is found to be in need of future medical care and related benefits or a settlement is reached between a patient and the patient's compensation fund in which the provision of medical care and related benefits is agreed upon and continuing as long as medical or surgical attention is reasonably necessary, the patient may make a claim to the patient's compensation fund through the office of the attorney general for all future medical care and related benefits directly or indirectly made necessary by the health care provider's malpractice unless the patient refuses to allow them to be furnished.

D. Payments for medical care and related benefits shall be paid by the patient's compensation fund without regard to the five hundred thousand dollar limitation imposed in R.S. 40:1299.42.

E. (1) The district court from which final judgment issues shall have continuing jurisdiction in cases where

medical care and related benefits are determined to be needed by the patient.

(2) The court shall award reasonable attorney fees to the claimant's attorney if the court finds that the patient's compensation fund unreasonably fails to pay for medical care within thirty days after submission of a claim for payment of such benefits.

F. Nothing in this Section shall be construed to prevent a patient and a health care provider and/or the patient's compensation fund from entering into a court-approved settlement agreement whereby medical care and related benefits shall be provided for a limited period of time only or to a limited degree.

G. The patient's compensation fund shall be entitled to have a physical examination of the patient by a physician of the patient's compensation fund's choice from time to time for the purpose of determining the patient's continued need of future medical care and related benefits, subject to the following requirements:

(1)(a) Notice in writing shall be delivered to or served upon the patient or the patient's counsel of record, specifying the time and place where it is intended to conduct the examination.

(b) Such notice must be given at least ten days prior to the time stated in the notice.

(c) Delivery of the notice may be by certified mail.

(2) Such examination shall be by a licensed medical physician or chiropractic physician licensed under the laws of this state or of the state, parish, or county wherein the patient resides.

(3)(a) The place at which such examination is to be conducted shall not involve an unreasonable amount of travel for the patient considering all circumstances.

(b) It shall not be necessary for a patient who resides outside this state to come into this state for such an examination unless so ordered by the court.

(4) Within thirty days after the examination, the patient shall be compensated by the party requesting the examination for all necessary and reasonable expenses incidental to submitting to the examination including the reasonable costs of travel, meals, lodging, loss of pay, or other direct expenses.

(5)(a) Examinations may not be required more frequently than at six months intervals except that, upon application to the court having jurisdiction of the claim and after reasonable cause shown therefor, examination within a shorter interval may be ordered.

(b) In considering such application, the court should exercise care to prevent harassment to the patient.

(6)(a) The patient shall be entitled to have a physician or an attorney of his own choice or both present at such examination.

(b) The patient shall pay such physician or attorney himself.

(7) The patient shall be promptly furnished with a copy of the report of the examination made by the physician making the examination on behalf of the patient's compensation fund.

H. If a patient fails or refuses to submit to examination in accordance with a notice and if the requirements of Subsection G of this Section have been satisfied, then the patient shall not be entitled to attorney fees in any action to enforce rights pursuant to Subsection E of this Section.

I. (1) Any physician selected by the patient's compensation fund and paid by the patient's compensation fund who shall make or be present at an examination of the patient conducted in pursuance of this Section may be required to testify as to the conduct thereof and the findings made.

(2) Communications made by the patient upon such examination by such physician or physicians shall not be considered privileged.

J. The patient's compensation fund shall pay all reasonable fees and costs of medical examinations and the costs and the fees of the medical expert witnesses in any proceeding in which the termination of medical care and related benefits is sought.

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§ 1299.44. Patient's compensation fund

A. (1) Subject to the exceptions contained in Article VII, Section 9(A) of the Constitution of Louisiana, all funds collected pursuant to the provisions hereof shall be paid into the state treasury and shall be credited to the Bond Security and Redemption Fund. Out of the funds

remaining in the Bond Security and Redemption Fund after a sufficient allocation is allocated from that fund to pay all obligations secured by the full faith and credit of the state due and payable within any fiscal year, the treasurer shall, prior to placing such remaining funds in the state general fund, pay into a special fund, which is hereby created in the state treasury and designated as the "Patient's Compensation Fund", in an amount equal to the total amount of funds paid into the treasury as a result of the voluntary collections from private health care providers provided for hereunder. The state recognizes and acknowledges that the fund and any income from it are not public monies, but rather are private monies which shall be held in trust as a custodial fund by the state for the use, benefit, and protection of medical malpractice claimants and the fund's private health care provider members, and all of such funds and income earned from investing the private monies comprising the corpus of this fund shall be subject to use and disposition only as provided by this Section.

(2)(a) In order to provide monies for the fund, an annual surcharge shall be levied on all health care providers in Louisiana qualified under the provisions of this Part.

(b) The surcharge shall be determined by the Louisiana Insurance Rating Commission based upon actuarial principles and in accordance with an application for rates or rate changes, or both, filed jointly by the commissioner of insurance and the office of the attorney general.

(c) The application for rate changes filed jointly by the commissioner of insurance and the office of the

attorney general shall be submitted on the basis of an annual actuarial study of the patient's compensation fund.

(d) The surcharge shall be collected on the same basis as premiums by each insurer, the risk manager, and surplus lines agents.

(e) The commissioner of insurance shall collect the surcharge from health care providers qualified as self-insureds.

(f) The surcharge for self-insureds shall be the amount determined by the insurance commissioner in accordance with regulations enacted under the Administrative Procedure Act of Louisiana and in accordance with the rate set by the Louisiana Insurance Rating Commission to be the amount of surcharge which the health care provider would reasonably be required to pay were his qualification based upon filing a policy of malpractice liability insurance.

(3) Such surcharge shall be due and payable to the patient's compensation fund within forty-five days after the premiums for malpractice liability insurance have been received by the agent of the insurer, risk manager, or surplus lines agent from the health care provider in Louisiana.

It shall be the duty of the insurer, risk manager, or surplus lines agent to remit the surcharge to the patient's compensation fund within forty-five days of the date of payment by the health care provider. Failure of the insurer, risk manager, or surplus lines agent to remit payment within forty-five days shall subject the insurer,

risk manager, or surplus lines agent to a penalty of 12% of the annual surcharge and all reasonable attorney's fees. Upon the failure of insurer, risk manager, or surplus line agent to remit as provided herein, the attorney general is authorized to institute legal proceedings to collect the surcharge, together with penalties, legal interest, and attorney's fees.

(4) If the annual premium surcharge is not paid within the time limited above, the certificate of authority of the insurer, risk manager, and surplus lines agents shall be suspended until the annual premium surcharge is paid.

(5)(a) All expenses of collecting, protecting, and administering the fund shall be paid from the fund.

(b) The functions of collecting and administering the fund shall be carried out by the insurance commissioner and his employees for an amount not to exceed the amount appropriated by the legislature.

(c) The function of protecting the fund, including all matters relating to establishing reserves, the evaluating and settlement of claims and relating to the defense of the fund, shall be carried out by the attorney general.

(d) The attorney general may enter into contracts with persons to perform services in connection with and relating to the defense of the fund and relating to the establishment of reserves, subject to the review of an independent actuary, for an amount not to exceed the amount appropriated by the legislature for this purpose.

(e) The function of selecting the list of attorney names from which the selection of the Attorney Chairman of the Medical Review Panels is to be made shall be the responsibility of the office of the clerk of the Louisiana Supreme Court.

(f) These expenses of the commissioner of insurance, office of the clerk of the Louisiana Supreme Court, and the attorney general shall be paid from the fund by the state treasurer in accordance with the law.

(g) The fund shall be a budget unit of this state.

(h) The legislature shall appropriate from the fund, sufficient monies for the carrying out by the insurance commissioner, office of the clerk of the Louisiana Supreme Court, and the attorney general of the duties, functions, and responsibilities imposed upon them in this Section, and shall also appropriate all remaining monies in the fund for use by the treasurer to pay final judgments, court approved settlements, final arbitration awards, and judgments awarding medical care and related benefits rendered pursuant to R.S. 40:1299.43 and vouchers drawn by the office of the attorney general pursuant to a judgment reciting that a patient is in need of future medical and related benefits under the provisions of R.S. 40:1299.43 in accordance with Paragraph (7) of this Subsection A, and in accordance with Subsection B of this Section.

(i) Any purchases from the fund of furniture, fixtures, equipment, or other property shall be specifically designated, by such method of identification as is reasonable and practical for each item, as the property of the fund.

(6)(a) If the fund exceeds the sum of fifteen million dollars at the end of any calendar year after the payment of all claims and expenses, the Louisiana Insurance Rating Commission in accordance with a rate filing request made jointly by the commissioner of insurance and the office of the attorney general may reduce the surcharge provided in this Subsection; however, at all times the fund shall be maintained so as to provide a surplus of fifty percent of the annual surcharge premiums, reserves established for individual claims, reserves established for incurred but not reported claims, and expenses.

(b) No reduction in the surcharge shall be made unless such surplus is available in the fund.

(7)(a) Claims from the patient's compensation fund exclusive of those provided for in R.S. 40:1299.43 shall be computed on June 30 and December 31 of the year in which the claim becomes final.

(b) The claims computed on June 30 shall be paid on or before July 15, and the claims computed on December 31 shall be paid on or before January 15.

(c) If the fund would be exhausted by payment in full of all claims allowed during the applicable semi-annual period, then the amount paid to each claimant shall be prorated.

(d) Any amounts due and unpaid shall be prorated.

(e) Any amounts due and unpaid shall be paid in the following semi-annual periods.

B. (1) The state treasurer shall issue a warrant in the amount of each claim submitted to him against the fund on June 30 and December 31 of each year except that

payment for claims made pursuant to R.S. 40:1229.44(B)(4) or (B)(5), or both, shall be made upon receipt of such certified copy.

(2) The only claim against the fund shall be a voucher or other appropriate request by the commissioner after he receives:

(a) A certified copy of a final judgment in excess of one hundred thousand dollars against a health care provider.

(b) A certified copy of a court approved settlement in excess of one hundred thousand dollars against a health care provider.

(c) A certified copy of a final award in excess of one hundred thousand dollars in an arbitration proceeding against a health care provider.

(d) A certified copy of a judgment awarding medical care and related benefits rendered pursuant to R.S. 40:1299.43.

(e) A voucher drawn by the office of the attorney general through the patient's compensation fund defense counsel pursuant to a judgment reciting that a patient is in need of future medical care and related benefits under the provisions of R.S. 40:1299.43.

C. If the insurer of a health care provider or a self-insured health care provider has agreed to settle its liability on a claim against its insured and claimant is demanding an amount in excess thereof from the patient's compensation fund for a complete and final release, then the following procedure must be followed:

(1) A petition shall be filed by the claimant with the court in which the action is pending against the health care provider, if none is pending in the parish where plaintiff or defendant is domiciled seeking (a) approval of an agreed settlement, if any, and/or (b) demanding payment of damages from the patient's compensation fund.

(2) A copy of the petition shall be served on the commissioner, the health care provider and his insurer, at least ten days before filing and shall contain sufficient information to inform the other parties about the nature of the claim and the additional amount demanded.

(3) The commissioner and the insurer of the health care provider or the self-insured health care provider as the case may be, may agree to a settlement with the claimant from the patient's compensation fund, or the commissioner and the insurer of the health care provider or the self-insured health care provider as the case may be, may file written objections to the payment of the amount demanded. The agreement or objections to the payment demanded shall be filed within twenty days after the petition is filed.

(4) As soon as practicable after the petition is filed in the court the judge shall fix the date on which the petition seeking approval of the agreed settlement and/or demanding payment of damages from the fund shall be heard, and shall notify the claimant, the insurer of the health care provider or the self-insured health care provider as the case may be, and the commissioner thereof as provided by law.

(5) At the hearing the commissioner, the claimant and the insurer of the health care provider or the self-

insured health care provider as the case may be, may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if it is submitted on agreement without objections. If the commissioner, the insurer of the health care provider or the self-insured health care provider as the case may be, and the claimant cannot agree on the amount, if any, to be paid out of the patient's compensation fund, then the court shall determine the amount of claimant's damages, if any, in excess of the amount already paid by the insurer of the health care provider. The court shall determine the amount for which the fund is liable and render a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid from the patient's compensation fund, the court shall consider the liability of the health care provider as admitted and established where the insurer has paid its policy limits of one hundred thousand dollars, or where the self-insured health care provider has paid one hundred thousand dollars.

(6) Any settlement approved by the court shall not be appealed. Any judgment of the court fixing damages recoverable in any such contested proceeding shall be appealable pursuant to the rules governing appeals in any other civil court case tried by the court.

(7) For the benefit of both the insured and the patient's compensation fund, the insurer of the health provider shall exercise good faith and reasonable care both in evaluating the plaintiff's claim and in considering and acting upon settlement thereof. A self-insured health care provider shall, for the benefit of the patient's compensation fund, also exercise good faith and reasonable

care both in evaluating the plaintiff's claim and in considering and acting upon settlement thereof.

(8) The parties may agree that any amounts due from the patient's compensation fund pursuant to R.S. 40:1299.44(B) be paid by annuity contract purchased by the patient's compensation fund for and on behalf of the claimant.

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§ 1299.45 Malpractice coverage

A.(1) Only while malpractice liability insurance remains in force, or in the case of a self-insured health care provider, only while the security required by regulations of the insurance commissioner remains undiminished, are the health care provider and his insurer liable to a patient, or his representative, for malpractice to the extent and in the manner specified in this Part.

(2) For, the purpose of this Part, qualification under the provisions of R.S. 40:1299.42(A) by either an individual health care provider or his professional health care corporation authorized by the provisions of Title 12 of the Louisiana Revised Statutes of 1950 composed solely of that individual health care provider shall serve to qualify both the individual health care provider and his professional health care corporation, if any, under the provisions of this Part without the payment of an additional surcharge.

B. The filing of proof of financial responsibility with the commissioner shall constitute, on the part of the insurer, a conclusive and unqualified acceptance of the provisions of this Part.

C. Any provision in a policy attempting to limit or modify the liability of the insurer contrary to the provisions of this Part is void, except that a provision in a malpractice liability insurance policy approved by the insurance commissioner which limits the aggregate sum for which the insurer may be liable during the policy period shall be valid.

D. Every policy issued under this Part is deemed to include the following provisions, and any change which may be occasioned by legislation adopted by the legislature of the state of Louisiana as fully as if it were written therein:

(1) The insurer assumes all obligations to pay an award imposed against its insured under the provisions of this Part; and

(2) Any termination of this policy by cancellation is not effective as to patients claiming against the insured covered hereby, unless at least thirty days before the taking effect of the cancellation, a written notice giving the date upon which termination becomes effective has been received by the insured and the commissioner at their offices. In no event shall said cancellation affect in any manner any claim which rose against the insurer or its insured during the life of the policy.

E. If an insurer fails or refuses to pay a final judgment, except during the pendency of an appeal, or fails,

or refuses to comply with any provisions of this Part, in addition to any other legal remedy, the commissioner may also revoke the approval of its policy form until the insurer pays the award or judgment or has complied with the violated provisions of this Part and has resubmitted its policy form and received the approval of the commissioner.

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§ 1299.46. Risk management; authority

A. The purpose of this Section is to make malpractice liability insurance available to qualified risks as defined in this Part.

B. There is created the Residual Malpractice Insurance Authority. The Department of Insurance is designated as the authority for the purpose of this Part. The authority is empowered to engage in making malpractice liability insurance in this state.

C. The commissioner shall choose a risk manager for the authority according to the public bid laws of the state.

Unless otherwise agreed between the risk manager and the commissioner, the separate, personal or independent assets of the risk manager shall not be liable for or subject to use or expenditure for the purpose of providing insurance by the authority.

All contracts between the commissioner and the risk manager, and any amendment thereto, and any adjustments made by the commissioner in the compensation or

duties of the risk manager permitted by such contracts shall require the approval of the Division of Administration.

D. In the administration and provision for malpractice liability insurance by the authority, the risk manager shall:

(1) Be subject to all laws and regulations of this state which apply to insurance. Except as provided by this Part the Residual Malpractice Insurance Authority shall not be subject to the taxes provided by the Louisiana Insurance Code;

(2) Prepare and file appropriate forms with the Department of Insurance;

(3) Prepare and file premium rates with the Department of Insurance;

(4) Perform the underwriting functions; and subject to the approval of the commissioner, shall formulate underwriting standards for insuring health care providers who by reason of training, experience, claims history and other generally accepted underwriting standards are reasonable insurance risks;

(5) Dispose of all claims and litigations arising out of insurance policies;

(6) Maintain adequate books and records;

(7) File an annual financial statement regarding its operations under this Section with the Department of Insurance on forms prescribed by the commissioner;

(8) Obtain private reinsurance for the authority, if necessary;

(9) Prepare and file for approval of the commissioner, a schedule of agent's compensation; and

(10) Prepare and file a plan of operations with the commissioner for approval.

E. Unless otherwise agreed between the risk manager and the commissioner, the risk manager shall receive as compensation for its services only a percentage of all premiums received by it under the terms of this Section, as determined by the commissioner and approved by the Division of Administration.

F. If a health care provider desires malpractice liability insurance under this Part, he shall forward his application to the risk manager. The risk manager shall not consider any application unless a health care provider furnishes in his application evidence of his having either been refused coverage by at least two private insurers writing medical malpractice insurance in the state, or having been refused coverage by the only private insurer writing medical malpractice insurance in the state, or that no private insurer is writing such insurance in the state. Upon written application therefor, the risk manager shall provide a malpractice liability insurance binder to a health care provider who has applied for medical malpractice insurance to any private insurer writing medical malpractice insurance in the state. Such binder shall remain in effect for no more than sixty days from the date of the application by the health care provider to such private insurer. Upon proof by the health care provider submitted to the risk manager that he has not been accepted by any private insurer during the sixty day period, the risk manager shall assume that the health care

provider has been rejected for private insurance coverage. In that case, the risk manager shall, if the health care provider meets the underwriting standards called for in Paragraph (4) of Subsection D of this Section, issue a policy of insurance to the health care provider. If within the sixty day period the applicant is accepted by a private insurer, the binder shall expire at the time of such acceptance.

G. If the risk manager declines to accept the risk, notice of declination, together with reasons, shall be sent to the applicant and the commissioner. The applicant shall have ten days from the date of notice to file an appeal for review by the commissioner. On appeal, the commissioner shall review the decision of the risk manager to determine whether the approved underwriting standards have been fairly applied by the risk manager and shall enter an appropriate order.

H. The surplus of premiums over losses and expenses received by the authority shall be placed in a segregated fund and shall be invested and reinvested by the risk manager with the concurrence of the commissioner in accordance with the insurance code of the state of Louisiana and investment income generated shall remain in the fund. These funds shall not be considered public or state funds.

I. The authority may issue malpractice liability insurance policies only to health care providers who are residents of Louisiana and to corporations, foreign or domestic, with regard to health care facilities operated within Louisiana. Insofar as practicable, only the claims experience of Louisiana health care providers shall be

considered in the determination of rates for such policies. The rates for such policies shall otherwise be determined and approved according to the same procedures and principles as rates for malpractice liability policies issued by private insurers in Louisiana. The rates for such policies shall be at least equal to the highest rate established for any particular category of malpractice liability insurance of a like policy issued by private insurers in the state.

J. The state of Louisiana assumes no liability for medical malpractice insurance policies written by the authority. Every policy issued by the authority shall contain a statement that the authority's liability or the liability of the policy is limited to the authority's reserves.

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§ 1299.47. Medical review panel.

A. (1) All malpractice claims against health care providers covered by this Part, other than claims validly agreed for submission to a lawfully binding arbitration procedure, shall be reviewed by a medical review panel established as hereinafter provided for in this Section.

(2)(a) The filing of the request for a review of a claim shall suspend the time within which suit must be instituted, in accordance with this Part, until ninety days following notification, by certified mail, as provided in Subsection J of this Section, to the claimant or his attorney of the issuance of the opinion by the medical review panel, in the case of those health care providers covered

by this Part, or in the case of a health care provider against whom a claim has been filed under the provisions of this Part, but who has not qualified under this Part, until sixty days following notification by certified mail to the claimant or his attorney by the commissioner that the health care provider is not covered by this Part.

(b) The request for review of the claim under this Section shall be deemed filed on the date of receipt of the complaint stamped and certified by the commissioner or on the date of mailing of the complaint if mailed to the commissioner by certified or registered mail.

(c) The commissioner shall dismiss a claim ninety days after giving notice by certified mail to the claimant or the claimant's attorney if no action has been taken by the claimant or the claimant's attorney to secure the appointment of an attorney chairman for the medical review panel within two years from the date the request for review of the claim was filed.

(3) It shall be the duty of the commissioner of insurance within fifteen days of the receipt of the claim to:

(a) Confirm to the claimant that the filing has been officially received and whether or not the named defendant or defendants have qualified under this Part.

(b) Notify all named defendants, whether or not qualified under the provisions of this Part, that a filing has been made against them and request made for the formation of a medical review panel; and forward a copy of the proposed complaint to each named defendant at his last and usual place of residence or his office.

(c) Forward a copy of the proposed complaint to the clerk of the Louisiana Supreme Court, including the names of the parties plaintiff and defendant, who are qualified under this Part.

B. (1)(a)(i) No action against a health care provider covered by this Part, or his insurer, may be commenced in any court before the claimant's proposed complaint has been presented to a medical review panel established pursuant to this Section.

(ii) A certificate of enrollment issued by the commissioner of insurance shall be admitted in evidence.

(b) However, with respect to an act of malpractice which occurs after September 1, 1983, if an opinion is not rendered by the panel within twelve months after the date of notification of the selection of the attorney chairman by the commissioner to the selected attorney and all other parties pursuant to Paragraph (1) of Subsection C of this Section, suit may be instituted against a health care provider covered by this Part. However, either party may petition a court of competent jurisdiction for an order extending the twelve month period provided in this Subsection for good cause shown. After the twelve month period provided for in this Subsection or any court-ordered extension thereof, the medical review panel established to review the claimant's complaint shall be dissolved without the necessity of obtaining a court order of dissolution.

(c) By agreement of both parties, the use of the medical review panel may be waived.

(2)(a) A health care provider, against whom a claim has been filed under the provisions of this Part, may raise any exception or defenses available pursuant to R.S. 9:5628 in a court of competent jurisdiction and proper venue at any time without need for completion of the review process by the medical review panel.

(b) If the court finds that the claim had prescribed or otherwise was perempted prior to being filed, the panel, if established, shall be dissolved.

(3) Ninety days after the notification to all parties by certified mail by the attorney chairman or the commissioner of the dissolution of the medical review panel or ninety days after the expiration of any court-ordered extension as authorized by Paragraph (1) of this Subsection, the suspension of the running of prescription with respect to a qualified health care provider shall cease.

C. The medical review panel shall consist of three health care providers who hold unlimited licenses to practice their profession in Louisiana and one attorney. The parties may agree on the attorney member of the medical review panel or if no agreement can be reached, then the attorney member of the medical review panel shall be selected in the following manner:

(1) The office of the clerk of the Louisiana Supreme Court, upon receipt of notification from the commissioner of insurance, shall draw five names at random from the list of attorneys who reside or maintain an office in the parish which would be proper venue for the action in a court of law. The names of judges, magistrates, district attorneys and assistant district attorneys shall be excluded if drawn and new names drawn in their place.

After selection of the attorney names, the office of the clerk of the supreme court shall notify the office of the commissioner of insurance of the names so selected. It shall be the duty of the office of the commissioner of insurance to notify the parties of the attorney names from which the parties may choose the attorney member of the panel within five days. If no agreement can be reached within five days, the parties shall immediately initiate a procedure of selecting the attorney by each striking two names alternately, with the claimant striking first and so advising the health care provider of the name of the attorney so stricken; thereafter, the health care provider and the claimant shall alternately strike until both sides have stricken two names and the remaining name shall be the attorney member of the panel. If either the plaintiff or defendant fails to strike, the clerk of the Louisiana Supreme Court shall strike for that party within five additional days.

After the striking, the office of the commissioner of insurance shall notify the attorney and all other parties of the name of the selected attorney.

(2) The attorney shall act as chairman of the panel and in an advisory capacity but shall have no vote. It is the duty of the chairman to expedite the selection of the other panel members, to convene the panel, and expedite the panel's review of the proposed complaint. The chairman shall establish a reasonable schedule for submission of evidence to the medical review panel but must allow sufficient time for the parties to make full and adequate presentation of related facts and authorities within ninety days following selection of the panel.

(3)(a) The plaintiff shall notify the attorney chairman and the named defendants of his choice of a health care provider member of the medical review panel within thirty days of the date of certification of his filing by the commissioner of insurance.

(b) The named defendant shall then have fifteen days after notification by the plaintiff of the plaintiff's choice of his health care provider panelist to name the defendant's health care provider panelist.

(c) If either the plaintiff or defendant fails to make a selection of health care provider panelist within the time provided, the attorney chairman shall notify by certified mail the failing party to make such selection within five days of the receipt of the notice.

(d) If no selection is made within the five day period, then the chairman shall make the selection on behalf of the failing party. The two health care provider panel members selected by the parties or on their behalf shall be notified by the chairman to select the third health care provider panel member within fifteen days of their receipt of such notice.

(e) If the two health care provider panel members fail to make such selection within the fifteen day period allowed, the chairman shall then make the selection of the third panel member and thereby complete the panel.

(f) The qualification and selection of physician members of the medical review panel shall be as follows:

(i) All physicians who hold a license to practice medicine in the state of Louisiana and who are engaged in the active practice of medicine in this state, whether in

the teaching profession or otherwise, shall be available for selection.

(ii) Each party to the action shall have the right to select one physician and upon selection the physician shall be required to serve.

(iii) When there are multiple plaintiffs or defendants, there shall be only one physician selected per side. The plaintiff, whether single or multiple, shall have the right to select one physician, and the defendant, whether single or multiple, shall have the right to select one physician.

(iv) A panelist so selected and the attorney member selected in accordance with this Subsection shall serve unless for good cause shown may be excused. To show good cause for relief from serving, the panelist shall present an affidavit to a judge of a court of competent jurisdiction and proper venue which shall set out the facts showing that service would constitute an unreasonable burden or undue hardship. A health care provider panelist may also be excused from serving by the attorney chairman if during the previous twelve month period he has been appointed to four other medical review panels. In either such event, a replacement panelist shall be selected within fifteen days in the same manner as the excused panelist.

(v) If there is only one party defendant which is not a hospital, community blood center, tissue bank, or ambulance service, all panelists except the attorney shall be from the same class and specialty of practice of health care provider as the defendant. If there is only one party defendant which is a hospital, community blood center,

tissue bank, or ambulance service, all panelists except the attorney shall be physicians. If there are claims against multiple defendants, one or more of whom are health care providers other than a hospital, community blood center, tissue bank, or ambulance service, the panelists selected in accordance with this Subsection may also be selected from health care providers who are from the same class and specialty of practice of health care providers as are any of the defendants other than a hospital, community blood center, tissue bank, or ambulance service.

(4) When the medical review panel is formed, the chairman shall within five days notify the commissioner and the parties by registered or certified mail of the names and addresses of the panel members and the date on which the last member was selected.

(5) Before entering upon their duties, each voting panelist shall subscribe before a notary public the following oath:

> "I, (name) do solemnly swear/affirm that I will faithfully perform the duties of medical review panel member to the best of my ability and without partiality or favoritism of any kind. I acknowledge that I represent neither side and that it is my lawful duty to serve with complete impartiality and to render a decision in accordance with law and the evidence."

The attorney panel member shall subscribe to the same oath except that in lieu of the last sentence thereof the attorney's oath shall state:

> "I acknowledge that I represent neither side and that it is my lawful duty to advise the panel

members concerning matters of law and procedure and to serve as chairman."

The original of each oath shall be attached to the opinion rendered by the panel.

(6) The party aggrieved by the alleged failure or refusal of another to perform according to the provisions of this Section may petition any district court of proper venue over the parties for an order directing that the parties comply with the medical review panel provisions of the medical malpractice act.

(7) A panelist or a representative or attorney for any interested party shall not discuss with other members of a medical review panel on which he serves a claim which is to be reviewed by the panel until all evidence to be considered by the panel has been submitted. A panelist or a representative or attorney for any interested party shall not discuss the pending claim with the claimant or his attorney asserting the claim or with a health care provider or his attorney against whom a claim has been asserted under this Section. A panelist or the attorney chairman shall disclose in writing to the parties prior to the hearing any employment relationship or financial relationship with the claimant, the health care provider against whom a claim is asserted, or the attorneys representing the claimant or health care provider, or any other relationship that might give rise to a conflict of interest for the panelists.

D. (1) The evidence to be considered by the medical review panel shall be promptly submitted by the respective parties in written form only.

(2) The evidence may consist of medical charts, x-rays, lab tests, excerpts of treatises, depositions of witnesses including parties, affidavits and reports of medical experts, and any other form of evidence allowable by the medical review panel.

(3) Depositions of the parties and witnesses may be taken prior to the convening of the panel.

(4) Upon request of any party, or upon request of any two panel members, the clerk of any district court shall issue subpoenas and subpoenas duces tecum in aid of the taking of depositions and the production of documentary evidence for inspection and/or copying.

(5) The chairman of the panel shall advise the panel relative to any legal question involved in the review proceeding and shall prepare the opinion of the panel as provided in Subsection G.

(6) A copy of the evidence shall be sent to each member of the panel.

E. Either party, after submission of all evidence and upon ten days notice to the other side, shall have the right to convene the panel at a time and place agreeable to the members of the panel. Either party may question the panel concerning any matters relevant to issues to be decided by the panel before the issuance of their report. The chairman of the panel shall preside at all meetings. Meetings shall be informal.

F. The panel shall have the right and duty to request and procure all necessary information. The panel may consult with medical authorities, provided the names of

such authorities are submitted to the parties with a synopsis of their opinions and provided further that the parties may then obtain their testimony by deposition. The panel may examine reports of such other health care providers necessary to fully inform itself regarding the issue to be decided. Both parties shall have full access to any material submitted to the panel.

G. The panel shall have the sole duty to express its expert opinion as to whether or not the evidence supports the conclusion that the defendant or defendants acted or failed to act within the appropriate standards of care as charged in the complaint. After reviewing all evidence and after any examination of the panel by counsel representing either party, the panel shall, within thirty days but in all events within one hundred eighty days after the selection of the last panel member, render one or more of the following expert opinions which shall be in writing and signed by the panelists:

(1) The evidence supports the conclusion that the defendant or defendants failed to comply with the appropriate standard of care as charged in the complaint.

(2) The evidence does not support the conclusion that the defendant or defendants failed to meet the applicable standard of care as charged in the complaint.

(3) That there is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court.

(4) Where Paragraph (2) above is answered in the affirmative, that the conduct complained of was or was not a factor of the resultant damages. If such conduct was

a factor, whether the plaintiff suffered: (a) any disability and the extent and duration of the disability, and (b) any permanent impairment and the percentage of the impairment.

H. Any report of the expert opinion reached by the medical review panel shall be admissible as evidence in any action subsequently brought by the claimant in a court of law, but such expert opinion shall not be conclusive and either party shall have the right to call, at his cost, any member of the medical review panel as a witness. If called, the witness shall be required to appear and testify. A panelist shall have absolute immunity from civil liability for all communications, findings, opinions and conclusions made in the course and scope of duties prescribed by this Part.

I. (1)(a) Each physician member of the medical review panel shall be paid at the rate of twenty-five dollars per diem, not to exceed a total of two hundred fifty dollars for all work performed as a member of the panel exclusive of time involved if called as a witness to testify in a court of law regarding the communications, findings, and conclusions made in the course and scope of duties as a member of the medical review panel, and in addition thereto, reasonable travel expenses.

(b) The attorney chairman of the medical review panel shall be paid at the rate of one hundred dollars per diem, not to exceed a total of two thousand dollars for all work performed as a member of the panel exclusive of time involved if called as a witness to testify in a court of law regarding the communications, findings, and conclusions made in the course and scope of duties as a member

of the medical review panel, and in addition thereto, reasonable travel expenses. The attorney chairman shall submit the amount due him for all work performed as a member of the panel by affidavit, which shall attest that he has performed in the capacity of chairman of the medical review panel and that he was personally present at all the panel's meetings or deliberations.

(2)(a) The costs of the medical review panel shall be paid by the health care provider if the opinion of the medical review panel is in favor of said defendant health care provider.

(b) The claimant shall pay the costs of the medical review panel if the opinion of the medical review panel is in favor of said claimant. However, if the claimant is unable to pay, the claimant shall swear under oath to the attorney chairman of the medical review panel that said claimant cannot afford the costs of the medical review panel as they accrue, then the costs of the medical review panel shall be paid by the health care provider, with the proviso that if the claimant subsequently receives a settlement or receives a judgment, the advance payment of the medical review panel costs will be offset.

(3) If the medical review panel decides that there is a material issue of fact bearing on liability for consideration by the court, the claimant and the health care provider shall split the costs of the medical review panel. However, in those instances in which the claimant is unable to pay his share of the costs of the medical review panel, the claimant shall swear under oath by the attorney chairman of the medical review panel that said claimant cannot pay his share of the costs of the medical

review panel as they accrue. The claimant's share of the costs of the medical review panel shall then be paid by the health care provider with the proviso that if the claimant subsequently receives a settlement or receives a judgment, the advance payment of the claimant's share of the costs of the medical review panel will be offset.

J. The chairman shall submit a copy of the panel's report to the commissioner and all parties and attorneys by registered or certified mail within five days after the panel renders its opinion.

K. In the event the medical review panel after a good faith effort has been unable to carry out its duties by the end of the one hundred eighty day period, as provided in R.S. 40:1299.47(G), either party or the commissioner, after exhausting all remedies available to them under this Section, may petition the appropriate court of competent jurisdiction for an order to show cause why the panel should not be dissolved and the panelists relieved of their duties. The suspension of the running of prescription shall cease sixty days after receipt by the claimant or his attorney of the final order dissolving the medical review panel, which order shall be mailed to the claimant or his attorney by certified mail.

L. Where the medical review panel issues its opinion after the one hundred eighty days required by this Section, the suspension of the running of prescription shall not cease until ninety days following notification by certified mail to the claimant or his attorney of the issuance of the opinion as required by Subsection J of this Section.

M. Legal interest shall accrue from the date of filing of the complaint with the commissioner of insurance on a judgment rendered by a court in a suit for medical malpractice brought after compliance with this Part.

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§ 1299.48 Reporting of claims

A. For the purpose of providing the various licensing boards of Louisiana health care providers, as defined by R.S. 40:1299.41(A)(1), with information on malpractice claims paid by insurers or self insurers on behalf of health care providers in this state, each insurer of such health care provider, and each health care provider in Louisiana who is self insured shall, within thirty days of the date of payment, provide a written report to the licensing board of this state having licensing authority over the health care provider on whose behalf payment was made, and each such report shall contain:

(1) The name and address of the health care provider.

(2) A brief description of the acts of omission or commission which gave rise or allegedly gave rise to the claim, and the date thereof.

(3) The name of the patient and the injury which resulted or allegedly resulted therefrom.

(4) The amount paid in settlement or discharge of the claim, whether paid by compromise, by payment of judgment, by payment of arbitration award, or otherwise; and

(5) Where any judicial opinion has been rendered with regard to a claim, a copy of all such opinions shall be attached to the report.

Provided, however, no report shall be required for compromise settlements of claims where the amount paid is one thousand dollars or less, except where such payments were made in satisfaction or compromise of judgment of court or of award of arbitrators.

B. The provisions of this Section shall apply to all health care providers in Louisiana, whether or not such health care provider has qualified under the provisions of this Part.

C. There shall be no liability on the part of any insurer or person acting for said insurer, for any statements made in good faith in the reports required by this Section.